CITY OF
COUNCIL BLUFFS, IOWA

EMPLOYEE AND DEPENDENT LIFE INSURANCE

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

MEDICAL, OPTICAL, RETAIL AND MAIL ORDER DRUGS

DENTAL EXPENSE COVERAGE

EFFECTIVE JULY 1, 2003

INTRODUCTION

Your benefit plan has been designed to provide financial help for you when a covered loss occurs. The plan is established through a Group Policy, issued by Us, Principal Life Insurance Company, and Plan Documents, established for the Planholder, City of Council Bluffs, Iowa.

The Medical, Optical, Retail and Mail Order Prescription Drugs, and Dental portions of this plan have been established on a noninsured basis; all liability for payment of benefits is assumed by the Planholder. While Principal Life Insurance Company administers payment of claims, Principal Life Insurance Company has no liability for the funding of the benefit plans.

For Medical, Optical, Retail and Mail Order Prescription Drugs, and Dental coverages, while one of Principal Life Insurance Company's function is to process claims according to the plan provisions, all claims under the plan are paid by the Planholder and the Planholder owns the claim files. Therefore, the final decision on any disputed claim may involve review of these files by the City of Council Bluffs, Iowa.

For the Medical, Optical, Retail and Mail Order Prescription Drugs, and Dental portions of the plans, the Planholder has complete discretion to construe or interpret all provisions, to determine eligibility for benefits, and to determine the type and extent of benefits, if any, to be provided. The Planholder's decisions in such matters shall be controlling, binding, and final. In any action to review any such decision by the Planholder, the Planholder shall be deemed to have exercised it discretion properly unless it is proved duly that the Planholder has acted arbitrarily and capriciously.

As a covered Employee of the plan, your rights and benefits are determined by the provisions of the Group Policy and Plan Documents. This booklet briefly describes those rights and benefits. It outlines what you must do to be covered. It explains how to file claims. For Life and Accidental Death and Dismemberment Insurance, it is your certificate while you are insured.

FUTURE OF PLAN. It is expected that this plan will be continued indefinitely. However, the Planholder does have the right to change or terminate the plan at any time.

PLEASE READ YOUR BOOKLET CAREFULLY. We suggest that you start with a review of the terms listed in the DEFINITIONS Section (at the back of the booklet). The meanings of these terms will help you understand the provisions of your plan.

PRINCIPAL LIFE
INSURANCE COMPANY
Des Moines, IA 50392-0001

YOUR ROLE IN CONTROLLING HEALTH CARE COSTS

Making choices about your health can sometimes be difficult. When you seek health care, take the same approach you use for buying anything else. Ask questions. Make sure you get the most appropriate care for your condition. Use the following guidelines to help you be a wise health care consumer:

Practice Good Health Habits. Staying healthy is the best way to control your medical costs. Eat a balanced diet, exercise regularly, and get enough sleep. Learn how to handle stress. Stop smoking and avoid excessive use of alcohol.

See Your Doctor Early. Don't let a minor problem become a major one. This makes treatment more difficult and expensive.

Make Sure You Need Surgery. If your plan includes a second opinion program, get one if you're unsure about the surgery you face. If you need surgery, ask about same day surgery. Many procedures can be performed safely without a Hospital stay. You have these surgeries as an outpatient or at a place other than a Hospital and go home the same day.

Use Outpatient Services for X-Ray or Laboratory Tests. Outpatient preadmission and diagnostic tests can save costly room and board charges.

Compare Prescription Drugs Prices. Discuss the use of generic drugs with your doctor or pharmacist. Generic drugs are often cheaper than brand name drugs for the same quality.

Consider Hospital Stay Alternatives. Home Health Care, Skilled Nursing Facilities, and Hospice Care services offer quality care in comfortable surroundings for less cost than staying in the Hospital.

Review Medical Bills Carefully. Make sure you understand all charges and receive bills only for services you receive. Keep your medical records up-to-date.

Talk to Your Doctor. Discuss the need for treatment with your doctor. It is your body. To make wise health care decisions, you must understand the treatment and any risks or complications involved. Ask about treatment costs too. With today's health care costs, your doctor will understand your concern about your medical expenses.

Be a wise health care consumer. Review your benefits carefully so you can make informed health care decisions. You can help control health care costs while getting the most your health care plan has to offer.

BENEFIT ADVICE

THE CLAIMS ADMINISTRATOR WANTS TO HELP YOU BE A WISE HEALTH CARE CONSUMER. PLEASE GIVE THE CLAIMS ADMINISTRATOR A CALL IF YOU HAVE ANY QUESTIONS ABOUT YOUR HEALTH CARE. SEE YOUR ID CARD FOR THE BENEFIT ADVICE PHONE NUMBER.

YOU MAY REFER TO THE CLAIM PROCEDURES SECTION OF THIS BOOKLET FOR MORE DETAILED INFORMATION.

TABLE OF CONTENTS

SUMMARY OF BENEFITS

This section highlights the benefits provided under your plan. The purpose is to give you quick access to the information you will most often want to review. Please read the other sections of this booklet for a more detailed explanation of your benefits and any limitations or restrictions that might apply.

EMPLOYEE LIFE INSURANCE

If you die, your beneficiary will be paid the Scheduled Benefit in force for you (however, see the exception noted below). The Scheduled Benefit is based on your class:

Class	*Basic Scheduled Benefits
All Employees	The Scheduled Benefit Amount as shown in the Group Policy.

Class	*Supplemental Scheduled Benefits
All Employees	You may choose, in increments of $10,000, a total Supplemental Benefit amount to a maximum of $100,000.

* The Scheduled Benefit is subject to the proof of good health requirements as shown in the Group Plan. If, because of these proof of good health requirements, We approve an amount of insurance that is different than the Scheduled Benefit, your beneficiary will be paid the approved amount.

* For the age(s) shown below, your amount of insurance will be the percentage of the Scheduled Benefit (or approved amount, if applicable) as shown below:

Age	% of Scheduled Benefit (or approved amount)
Age 70 and over	50%

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Class	*Scheduled Benefits
All Employees	The Scheduled Benefit Amount as shown in the Group Policy.

If you are injured and otherwise qualify, We will pay the following percentages of your Scheduled Benefit (or approved amount, if applicable) in force:

- 50% if you lose a hand, a foot, or the sight of one eye; or
- 100% if more than one of the listed losses results from the same accident; or
- 100% if you lose your life.

Payment for loss of life will be to your beneficiary. Payment for any other loss will be to you. The Scheduled Benefit is based on your class.

* The Scheduled Benefit is subject to the proof of good health requirements as shown in the Group Plan. If, because of these proof of good health requirements, We approve an amount of insurance that is different than the Scheduled Benefit, your beneficiary will be paid the approved amount.

* For the age(s) shown below, your amount of insurance will be the percentage of the Scheduled Benefit (or approved amount, if applicable) as shown below:

Age	**% of Scheduled Benefit (or approved amount)**
Age 70 and over	50%

DEPENDENT LIFE INSURANCE

If one of your Dependents dies, you will be paid the Scheduled Benefit then in force for that Dependent. The Scheduled Benefit is based on the status of your Dependent:

Status	**Scheduled Benefits**
Spouse	$ 10,000
Children (age at death)	
14 days but less than 6 months	500
6 months and older	5,000

SUMMARY OF BENEFITS

COMPREHENSIVE MEDICAL EXPENSE COVERAGE

If you or one of your Dependents is sick or injured, Scheduled Benefits then in force will be payable for Medically Necessary Care. Scheduled Benefits are based on your class:

Class	Scheduled Benefit
All Employees and their Dependents.....	Comprehensive Medical, Retail and Mail Order Prescription Drugs, and Optical Expense Coverage

Preferred Provider Organization (PPO)

Your employer has agreed to participate in a Preferred Provider Organization (PPO) network identified by the Claims Administrator for this plan.

As you may know, Preferred Provider Organization networks are arrangements whereby Hospitals, Physicians, and other providers are contracted to furnish, at negotiated costs, medical care for the employees (and their Dependents) of participating employers.

A current listing of the participating Hospitals, Physicians, and other providers is available through an on-line Preferred Provider directory. By accessing the Principal Life Insurance Company website www.principal.com, you can review Preferred Provider directories for your PPO Network shown on your I.D. card. Click on "Provider Directory," then "Search for a Participating Provider," then "Click Here for Network Selection." The name of your PPO network will then be listed and you can continue to follow the prompts. If you do not have internet access, you can request a paper copy of the provider directory from your employer. Whether using the internet or paper directory, the Claims Administrator recommends that you (1) verify your provider's participation in the network before seeking treatment and (2) confirm PPO participation with your provider when making your appointment.

It is expected that your employer's participation in the PPO will result in significant savings of funds needed to maintain your plan. Some of these savings will be passed on to you in the form of higher plan benefits payable for services received by you or a Dependent from Preferred Providers.

Please note that your employer's participation in the PPO network does not mean that your choice of provider will be restricted. You may still seek needed medical care from any Hospital, Physician, or other provider you wish. However, in order to avoid higher charges and reduced benefit payments, you are urged to obtain such care from Preferred Providers whenever possible.

The Plan administrator has the right to terminate the PPO portion of this plan if the Plan administrator or the PPO terminate the arrangement. In the event of termination, the Plan administrator will pay the level of benefits as described for medical care received from "Non-PPO Providers." In addition, the Cost Containment Administrator will assume responsibility for assisting you and your Dependents with the Hospital Admission Review and Pretreatment Review requirements described under the heading "Utilization Management Requirements."

Benefits Payable

Benefits will be payable during a Calendar Year as shown below, and will vary depending upon whether or not needed care is received from a Hospital, Physician, or other provider who has contracted with the Preferred Provider Organization network (see below).

MEDICAL EXPENSE BENEFITS		
	PPO PROVIDER	**NON-PPO PROVIDER**
Lifetime Payment Limit	Unlimited	
Calendar Year Deductible • Per Person • Per Family	 $ 100 $ 300	
Office Visit Copay Amounts	$10 per visit	$20 per visit
Out-of-Pocket Maximum • Per Person • Per Family	 $ 1,000 $ 2,000	
If the amount you pay for Covered Charges in any one calendar year reaches the Out-of-Pocket Expense Maximum, Medical benefits payable for the remainder of the calendar year will be 100% of any additional Covered Charges. Per visit Copays and Cost Containment Penalties do not apply to the Out-of-Pocket Maximums.		

SERVICE	PPO PROVIDER	NON-PPO PROVIDER
Inpatient & Outpatient Hospital	90% after Deductible	80% after Deductible
Physician Hospital Services Includes surgery and Physician visits.	90% after Deductible	80% after Deductible
Physician Office & Home Visits	100% after a $10 Copay	80%* after a $20 Copay
* The 20% Coinsurance amount you pay in excess of the per visit Copay amount will be counted toward satisfaction of the Out-of-Pocket Expense Maximum shown above, but will not be counted toward satisfaction of the Calendar Year Deductible.		
Diagnostic X-Ray and Lab		
• At a LabOne Facility	100% (Deductible Waived)	100% (Deductible Waived)
• At other than a LabOne Facility	90% after Deductible	80% after Deductible
If diagnostic x-ray and laboratory services are part of a Physician's office or home visit, the applicable Copay amounts ($10 or $20) will be required.		
Durable Medical Equipment	80% after Deductible	80% after Deductible
Nursing Facility Services	80% after Deductible	80% after Deductible
Limited to 120 days of confinement that result from the same or related sickness or injury.		
Home Health Care	80% after Deductible	80% after Deductible
Limited to 100 visits per Calendar Year.		

SERVICE	PPO PROVIDER	NON-PPO PROVIDER
Hospice Care	80% after Deductible	80% after Deductible
Limited to $10,000 for any one Episode of Hospice Care.		
Ambulance Services	80% after Deductible	80% after Deductible
All Other Covered Charges	80% after Deductible	80% after Deductible

MENTAL AND NERVOUS DISORDERS ALCOHOLISM AND DRUG ABUSE		
SERVICE	**PPO PROVIDER**	**NON-PPO PROVIDER**
Inpatient Hospital Services	90% after Deductible	80% after Deductible
Benefits will be limited to 30 days of confinement each Calendar Year.		
Outpatient Visits	100% after $10 Copay	80% after $20 Copay
The Maximum Benefit Payable for all services applies to combined PPO Provider and Non-PPO Provider charges.		

Uncontrollable Providers

For emergency room Physician charges, anesthesiology, radiology, and pathology services provided by a Non-PPO Provider, benefits will be payable at the PPO level when such services are provided at a PPO Hospital (inpatient, outpatient, and Hospital emergency room) or a licensed PPO freestanding surgical center.

Benefits Payable - Outpatient Laboratory Services

LabOne is a laboratory provider that conducts outpatient testing. An agreement has been established with LabOne to provide these services at a negotiated rate.

"Laboratory Services" means Covered Charges for testing of materials, fluids, or tissues obtained from patients for the purpose of screening, diagnosing or monitoring a condition and for determining appropriate treatment.

When you or your Dependent require outpatient Laboratory Services, you or your Physician may choose any laboratory you wish. However, if you **present your Lab Card** and request that the services of a LabOne facility be used, **your outpatient laboratory testing will be FREE**.

When utilizing a LabOne facility, there are two ways in which laboratory work is completed:

- Specimens are drawn at the Physician's office and are sent to LabOne for testing; or
- The covered individual visits a LabOne patient service center with a Physician's directive and has the specimen drawn. The specimen is then sent to the centralized laboratory for testing.

If you or your Dependent goes to a Physician's office or clinic *and the Physician sends the laboratory work to a LabOne facility for processing* benefits will be paid at 100% of Covered Charges for the Laboratory Services. No Copay or Deductible will be applied to these services.

If you or your Dependent goes to a Physician's office or clinic *and the Physician sends the laboratory work to a non-LabOne facility*, regular benefits will apply, including any applicable Deductibles or Copays.

If you or your Dependent goes to a LabOne facility *with a Physician's directives*, benefits will be paid at 100% of Covered Charges for the Laboratory Services. If the laboratory facility is not a LabOne facility, regular benefits will apply including any applicable Deductibles or Copays.

If you have questions about the Lab Card program, please call Clinical Client Services at:

1-800-646-7788]

Common Accident Provision

When two or more persons in the same family (you and your Dependents) are injured in the same accident, Covered Charges for all treatment or service that results from the injuries may be combined, if doing so would result in higher benefit payment.

In such cases, the injured persons' individual Deductible for the Calendar Year in which the accident occurs and for the next Calendar Year, will be replaced with a common Deductible.

However, this common Deductible will apply only to treatment or service resulting from the accident. For any other injury, you and each of your Dependents must satisfy the individual Deductible in the normal manner before benefits will be payable under Comprehensive Medical.

Utilization Management Requirements - Non-PPO Providers

Comprehensive Medical benefits payable for Hospital Inpatient Confinement Charges and Surgery Related Charges will be reduced by $300 per occurrence unless:

- for Hospital Inpatient Confinement Charges, a Hospital Admission Review is requested by you, a family member, or a Physician prior to, but no later than, the day of admission to a Hospital (for other than a Medical Emergency); and for a Medical Emergency, within two working days following a Hospital admission or as soon as reasonably possible thereafter. If a Hospital Admission Review is not requested in a timely manner as specified above, the $300 per occurrence reduction in benefits payable will be applied, but only to the charges incurred up to the date a Hospital Admission Review is obtained. **Benefits will be payable only for that part of the Hospital Inpatient Confinement Charges that the Cost Containment Administrator determines to be Medically Necessary Care**. **See page GH 407 CC for a complete description of Utilization Review. Certain exceptions apply to Hospital Inpatient Confinement Charges for maternity as described on page GH 407 CC**; and

- For all charges incurred for services listed on page GH 407 CC, under Pretreatment Review, a Pretreatment Review is requested from the Cost Containment Administrator by you, your Dependent, or a designated patient representative as soon as the service is scheduled but no later than the day the service begins or is continued, unless it is demonstrated that a Medical Emergency existed.

  Benefits will be payable only for services the Cost Containment Administrator determines to be Medically Necessary Care.

The $300 per occurrence reduction in benefits payable is a penalty for failure to comply with any of the Utilization Management Requirements listed. The reduction will not count toward satisfaction of the Out-of-Pocket Expense limits amount shown above.

For maternity coverage, a Hospital Admission Review is not a Utilization Management requirement for Hospital Confinement Charges for up to 48 hours following a vaginal delivery and 96 hours following a cesarean section, excluding the day of delivery. See page GH 400 for a description of this provision.

NOTE: SEE PAGE GH 407 CC FOR THE LIST OF CONDITIONS AND PROCEDURES THAT REQUIRE A PRETREATMENT REVIEW; AND

NOTE: SEE PAGE GH 146-1 FOR IMPORTANT CLAIM PROCEDURES INFORMATION ON FILING YOUR MEDICAL CLAIMS.

Cost Containment Requirements - Your Responsibilities

If you use providers outside the PPO network, your medical ID card gives a toll-free telephone number to call for Hospital and Pretreatment reviews. You must follow all of the requirements described on page GH 407 CC--Utilization Review or your benefits will be reduced as described above.

If you use the PPO, your PPO Physician automatically handles Hospital Admission Review and Pretreatment Review.

RETAIL AND MAIL ORDER PRESCRIPTION DRUGS EXPENSE COVERAGE

Benefits Payable

If drugs and medicines are prescribed to treat you or one of your Dependents for a sickness or injury, Retail and Mail Order Prescription Drugs benefits payable will be 100% of Covered Charges, in excess of the Copay amount described below, for each prescription or each refill.

PRESCRIPTION DRUGS		
	RETAIL DRUGS	**MAIL ORDER DRUGS**
Generic Drugs **Brand Name Drugs**	$5 Copay $10 Copay	$5 Copay $10 Copay
Maximum Supply	34-day supply or 100-Unit dose for each prescription and each refill	90 days for each prescription and each refill

If you or one of your Dependents uses a Nonmember Pharmacy, Covered Charges may only be reimbursed up to the amount determined by the Payment Schedule established by the Pharmacy Benefit Manager for each prescription or refill.

The majority of Generic Prescription Drugs are available at the lowest generic Copay. However, some generics are more expensive and are priced comparable to the Brand Name Drug. In those situations, you may be charged the Brand Name Drug Copay. In order to qualify for the generic Copay, a drug must be classified as generic by First DataBank/Medispan.

NOTE: To file a claim for benefits when utilizing a Member Pharmacy, contact the Pharmacy Benefit Manager at the address shown on the claim form or on your or your Dependent's identification card. To file a claim for benefits when utilizing a Nonmember Pharmacy or when an identification card is not utilized at a Member Pharmacy, submit a prescription drug claim form to the Pharmacy Benefit Manager.

If a prescription drug is not covered under Prescription Drug Expense Coverage (GH 424-1) or Mail Order Maintenance Prescription Drug Expense Coverage (GH 425), it may be submitted for consideration under Medical Expense Coverage.

OPTICAL EXPENSE COVERAGE

Optical Expense benefits payable will be:

- 100% of charges; but
- not more than the Maximum Payment Limit shown for each examination or vision aid.

VISION CARE	
SERVICES	**MAXIMUM PAYMENT LIMIT**
Complete Visual Analysis	$ 40 - one exam every 12 consecutive months
Single Lenses (pair)*	$ 30
Bifocal Lenses (pair)*	$ 50
Trifocal Lenses (pair)*	$ 75
Lenticular Lenses (pair)*	$ 125
Frames	$ 75 - one set every 24 consecutive months
Contact Lenses*	$ 125
* No more than one exam and/or two lenses (one pair) every 12 consecutive months (24-months for frames).	

SUMMARY OF BENEFITS

DENTAL EXPENSE COVERAGE

If you or one of your Dependents receives dental treatment or service listed under the Schedule of Dental Procedures, Scheduled Benefits then in force will be payable. Scheduled benefits are based on your class and the status of your Dependents:

Class	Scheduled Benefits
All Employees and their Dependent Spouses.....	All benefits for Covered Charges under Dental Care Parts 1, 2, and 3
Dependent Children	All benefits for Covered Charges under Dental Care Parts 1, 2, 3, and 4

DENTAL EXPENSE COVERAGE	
Calendar Year Deductible	
Part 1	None
Parts 2 and 3 (combined)	$50
Part 4	$50
In place of individual Deductibles, a family maximum Deductible may be applied. The family maximum Deductible will be a combined family total of $150 per Calendar Year for Covered Charges under Dental Care Parts 2, 3 and 4 (but not counting more than $50 per Calendar Year for any one person in your family). When the family maximum Deductible is satisfied for a Calendar Year, Dental benefits will be payable as if the individual Deductibles had been satisfied for each person in your family.	
Maximum Payment Limits	
Parts 1, 2, and 3 (combined)	$ 1,000 Per calendar year
Orthodontia	$ 1,000 Per lifetime
Dental Care Parts	
Part 1 - Diagnostic and Preventive Services	100% Deductible waived
Part 2 - Basic Restoration Services	80% *
Part 3 - Major Restoration Services	50% *
Part 4 - Orthodontia	50% *
In excess of any applicable Deductible amounts, up to the Dental Maximum Payment Limits.	
Dental Treatment Plan	
When charges for a Period of Dental Treatment (other than emergency treatment) are expected to exceed **$200,** a Dental Treatment Plan must be filed with the Claims Administrator before treatment begins. A form is available for this purpose. Upon receipt of the Dental Treatment Plan, the Claims Administrator will indicate the benefits payable for the proposed treatment and return the form to the attending Dentist.	

Deferred Coverage Provision

Benefits for Covered Charges under Dental Care Parts 2, 3, and 4 will be limited if you or if any of your Dependents become covered under the Deferred Coverage provision described in the HOW TO BE COVERED Section) on pages GH 116/126.

Dental Shared Savings Program

Your employer has agreed to participate in a Dental Shared Savings Program. The Shared Savings Program provides access to dentists nationwide through which you can receive treatment at a negotiated rate. You may seek dental care from any provider, however, your out-of-pocket expenses will be reduced if care is provided by a Dentist in The Principal Plan Dental Preferred Provider Organization (PPO) network.

To locate a provider participating in the Shared Savings Program, just visit www.principal.com 24 hours a day, 7 days a week. Or call 1-800-832-4450, 7:00 a.m. to 5:00 p.m. CST.]

HOW TO BE COVERED

EMPLOYEE LIFE INSURANCE
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
DEPENDENT LIFE INSURANCE

Employees

a. Eligibility

To be eligible for coverage you must be an Employee as defined in the DEFINITIONS Section.

You will be eligible on the first of the calendar month coinciding with or next following the date you complete one month of continuous active employment.

b. Proof of Good Health

In some instances, proof of your good health will be required to place your coverage in force. The type and form of required proof will be determined by Us. You will need to file proof of good health:

(1) if you request coverage more than 31 days after the date you are eligible. You must pay the cost of obtaining proof in this instance; and
(2) to become insured, initially or through future increases, for any Employee Supplemental Life Insurance Scheduled Benefit amount in excess of the amount shown in the Group Policy. We will pay the reasonable cost of proof required in this instance.

c. Effective Date for Initial Coverage

If you are required to contribute toward the cost of your coverage, your coverage will normally be in force on:

(1) the date you are eligible, if you make application for initial coverage on a form provided by your employer, on or before the date you are eligible; or
(2) the first of the calendar month coinciding with or next following the date you make application, if you make application within 31 days after the date you are eligible.

If you are not required to contribute toward the cost of your coverage, your coverage will normally be in force on the date you are eligible.

If proof of good health is required, your coverage will normally be in force on the later of:

(1) the date coverage would have been effective had proof not been required; or
(2) the first of the calendar month coinciding with or next following the date proof is approved.

However, if you are not Actively at Work on the date coverage would otherwise be effective, your coverage will not be in force until the day you return to Active Work.

d. Effective Date for Benefit Changes

A change in your Scheduled Benefit amount will normally be effective on the July 1, coinciding with or next following the date of the change in status.

However, if you are not Actively at Work on the date the change would otherwise be effective, the change will not be in force until the day you return to Active Work. Exception: decreases in Employee Basic and Supplemental Life Insurance and Accidental Death and Dismemberment Insurance Schedule Benefit amounts are effective on the date noted above whether or not you are Actively at Work.

e. Termination

Unless continued as provided in GH 117 C and GH 117 D, your coverage will cease on the earliest of:

(1) the date the Group Plan terminates; or
(2) the end of the calendar month in which you cease to belong to a class for which coverage is provided; or
(3) the end of the calendar month you cease to make any required contributions; or
(4) the end of the calendar month in which you cease to be an Employee; or
(5) the end of the calendar month in which you cease Active Work (however, under certain conditions, your coverage may be continued as described on page 13 under "Continuation due to sickness, injury, temporary layoff, or leave of absence"); or
(6) the date you enter the Armed Forces of any country.

Dependents

a. Eligibility

Your Dependents will be eligible for coverage on the later of:

(1) the date you are eligible for Employee coverage; or
(2) the date you first acquire a Dependent.

If your Dependent is employed and is covered under a group plan or plans provided by your Dependent's employer, the date such coverage is terminated because your Dependent is no longer eligible under his/her employer's plan will be considered the date you first acquire that Dependent (and any other Dependent who was also covered under such group plan or plans).

b. Effective Date

Coverage for your Dependents will be in force under the same terms as described above for Employees. Coverage will be effective for your Dependents as long as you are covered for Employee coverage, except:

(1) A Dependent acquired after your Dependent coverage is already in force will be covered on the date acquired.
(2) Any required proof of good health will be for the health of your Dependents.
(3) If a Dependent is in a Period of Limited Activity on the date initial Dependent coverage would otherwise be effective, the Dependent will not be covered until the Period of Limited Activity ends.

(4) If a Dependent is in a Period of Limited Activity on the date an increase in Dependent Life Insurance Scheduled Benefits would otherwise be effective, the increase will not be in force until the Period of Limited Activity ends.
(5) A newborn child will be covered when the child is 14 days old, if your Dependent coverage is then in force.

c. Termination

Unless continued as provided in GH 117 C and GH 117 D, coverage for your Dependents will terminate on the earliest of:

(1) the end of the calendar month in which you cease to belong to a class for which Dependent coverage is provided; or
(2) the end of the calendar month you cease to make any required contributions; or
(3) the date Dependent coverage is removed from the Group Plan; or
(4) the date your Employee coverage ceases; or
(5) the date he or she ceases to be your Dependent.

Employees and Dependents

Continuation due to sickness, injury, temporary layoff, or leave of absence

a. If you cease Active Work because of sickness or injury, your, and your Dependent's, coverage will continue during your sickness or injury until discontinued by the City.

b. If you cease Active Work because of temporary layoff, your, and your Dependent's, coverage will be continued until discontinued by the City, but in no event beyond one month after the last day of the calendar month in which you ceased Active Work.

c. If you cease Active Work due to an approved leave of absence, your, and your Dependent's, coverage will be continued until discontinued by the City, but in no event beyond six months after the last day of the calendar month in which you cease Active Work.

d. If you are interested in continuing your, and your Dependent's, coverage beyond the date it would normally terminate, you should consult with your employer before your coverage terminates.

HOW TO BE COVERED

EMPLOYEE AND DEPENDENT COMPREHENSIVE MEDICAL, OPTICAL, RETAIL AND MAIL ORDER PRESCRIPTION DRUGS, DENTAL EXPENSE COVERAGE

Employees

a. Eligibility

To be eligible for coverage you must be an Employee as defined in the DEFINITIONS Section.

You will be eligible on the first of the calendar month coinciding with or next following the date you complete one month of continuous active employment.

b. Effective Date for Noncontributory Coverage

Coverage for which you do not contribute toward the cost of the plan will be in force on the date you are eligible. You will be eligible on the first of the calendar month coinciding with or next following the date you complete one month of continuous active employment. You must request initial coverage on a form provided by your employer.

c. Effective Date for Contributory Coverage

You must request initial coverage on a form provided by your employer. If you are required to contribute toward the cost of your coverage, your coverage will be in force on:

(1) the date you are eligible, if you make application for coverage on a form provided by your employer, on or before the date you are eligible; or
(2) the first of the calendar month coinciding with or next following the date you make application, if you make application within 31 days after the date you are eligible.

If request for contributory coverage is made more than 31 days after the date you are eligible, and other than during a Special Enrollment Period described below, your coverage will be subject to the Late Enrollment provisions described below.

If request for contributory coverage is made more than 31 days after the date your are eligible, but during a Special Enrollment Period described below, your coverage will be effective as described below.

d. Termination

Unless continued as provided on GH 117 A, GH 117 B, GH 117 C and GH 117 D, your coverage will cease on the earliest of:

(1) the date the plan terminates; or
(2) the end of the calendar month in which you cease to belong to a class for which coverage is provided; or
(3) the end of the calendar month you cease to make any required contributions; or

(4) the end of the calendar month in which you cease to be an Employee; or
(5) the end of the calendar month in which you cease Active Work (however, under certain conditions, your coverage may be continued as described under "Continuation due to sickness, injury, temporary layoff, or leave of absence"); or
(6) the date you enter the Armed Forces of any country.

Dependents

a. Eligibility

Your Dependents will be eligible for coverage on the later of:

(1) the date you are eligible for Employee coverage; or
(2) the date you first acquire a Dependent.

For Optical, Retail and Mail Order Prescription Drugs, and Dental Expense Coverage: If your Dependent is employed and is covered under a group plan or plans provided by your Dependent's employer, the date such coverage is terminated because your Dependent is no longer eligible under his/her employer's plan will be considered the date you first acquire that Dependent (and any other Dependent who was also covered under such group plan or plans). Termination of coverage that has been continued under any state or federal continuation provisions will not be considered as a qualifying event for the purpose of these provisions.

b. Effective Dates

Dependent coverage is available only if you are currently covered for Employee coverage. If you are eligible for Dependent coverage, such coverage will be in force under the same terms as described earlier for Employee coverage.

If Dependent coverage is in force for any other Dependent, a new Dependent will be covered on the date acquired. Request for coverage is not required provided you notify your employer of the new Dependent within 31 days after the date the Dependent is acquired. For medical benefits for a newborn Dependent, effective date provisions are modified as described below.

c. Coverage for a Newborn Child

A newly born or newly adopted child will be covered for medical benefits from the moment of birth, or on the date of adoption or Placement for Adoption (whichever is earlier), provided the child meets the definition of a Dependent. For a newborn child, no contributions are required for the child's coverage during the 31-day period following the date of birth, adoption, or Placement for Adoption.

However, if you are required to contribute toward the cost of Dependent coverage, you must notify your employer within 31 days after the date of birth, adoption, or Placement for Adoption in order to continue the child's coverage beyond the 31-day period. If such notice is not given to your employer within the 31-day period, the child will be subject to the Late Enrollee provisions.

If your child's coverage terminates because you fail to request coverage (or pay the required contribution) within the 31-day period following your child's date of birth, adoption, or Placement for Adoption, benefits will be payable only for covered expenses incurred by the child during the 31-day period in which coverage was in force. The Individual Purchase Rights will not apply to the child.

d. Termination

Unless continued as provided in GH 117 A, GH 117 B, GH 117 C, and GH 117 D, coverage for your Dependents will terminate on the earliest of:

(1) the end of the calendar month in which you cease to belong to a class for which Dependent coverage is provided; or
(2) the end of the calendar month you cease to make any required contributions; or
(3) the date Dependent coverage is removed from the plan; or
(4) the date your Employee coverage ceases; or
(5) the date he or she ceases to be your Dependent.

However, Medical, Optical, Retail and Mail Order Prescription Drugs, and Dental Expense Coverages will be continued beyond the maximum age for a Dependent child who is incapable of self-support because of Developmental Disability or Physical Handicap and is dependent on you for primary support. You must apply for this continuation within 31 days after the child reaches the maximum age.

e. Dependents Who Lose Eligibility Due to Your Death

If you should die while covered, your Dependent's Medical, Optical, Retail and Mail Order Prescription Drugs, and Dental Expense Coverages will be continued until the earlier of:

(1) the date Dependent coverage would otherwise cease; or
(2) the date the plan is terminated; or
(3) the 91st day after the date of your death.

<u>Employees and Dependents</u>

a. Late Enrollment Provisions - Applicable to Medical Coverage Only

(1) Late Enrollee: Late Enrollee means, with respect to coverage under an employer's Group Health Plan, an Employee or Dependent who enrolls under the plan:

(a) other than during the 31-day period beginning on the date you are eligible to enroll under the plan; or
(b) other than during a Special Enrollment Period as described below.

For the purpose of the first item listed, only the most recent period of eligibility will be considered in determining whether an individual is a Late Enrollee if:

(a) the individual loses eligibility due to termination of employment or due to a general suspension of the plan; and
(b) the individual later becomes eligible again due to resumption of employment or due to resumption of the plan's coverage.

(2) Penalty for Late Enrollment

Coverage for a Late Enrollee will be deferred until the next Annual Open Enrollment Period described below, provided:

(a) for Employee coverage, you are an eligible employee; and
(b) for Dependent coverage, the Dependent continues to meet the plan's definition of Dependent.

(3) Annual Open Enrollment Period

If you are not yet covered under your employer's plan, and provided you and/or your Dependent(s) meet the eligibility requirements described in this booklet, you and/or your Dependent(s) may enroll for coverage during the Annual Open Enrollment Period. The Annual Open Enrollment Period will be the period from **January 1 through January 31**, of each year, with coverage beginning on **February 1**, of that year.

(4) Special Enrollment Periods

If you or one of your Dependents request enrollment after the 31-day period beginning the date you are eligible to enroll, but during a Special Enrollment Period as described below, you and/or your Dependent(s) will be a Special Enrollee and will not be considered a Late Enrollee. The Penalty for Late Enrollment will not apply to a Special Enrollee.

The Special Enrollment Periods are:

(a) Loss of Other Coverage: A Special Enrollment Period will apply to you or your Dependent if all of the following conditions are met:

(i) you or your Dependent were covered under another Group Health Plan or had other health coverage at the time of initial eligibility, and declined enrollment solely due to the other coverage; and
(ii) the other coverage terminated due to loss of eligibility (including loss due to legal separation, divorce, death, termination of employment or reduction in work hours), or due to termination of employer contributions (or, if the other coverage was under a COBRA or state continuation provision, due to exhaustion of the continuation); and
(iii) request for enrollment is made within 31 days after the other coverage terminates.

Coverage for you and/or your Dependent(s) will be effective on the first of the calendar month coinciding with or next following the date of the request for enrollment.

(b) Life-Event Changes: A Special Enrollment Period will apply to you or your Dependent if:

(i) You are enrolled, (or are eligible to be enrolled but have failed to enroll during a previous enrollment period); and
(ii) a person becomes your Dependent through marriage, birth, adoption, or Placement for Adoption; and
(iii) request for enrollment is made within 31 days after the date of the marriage, birth, adoption, or Placement for Adoption.

The effective date of your or your Dependent's coverage will be:

(i) In the event of marriage, the date of marriage; or

(ii) in the event of a Dependent child's birth, the date of such birth; or
(iii) in the event of a Dependent child's adoption or Placement for Adoption, the date of such adoption or Placement for Adoption.

(c) Court-Ordered Coverage: A Special Enrollment Period will apply to your Dependent child if:

(i) you are enrolled but have failed to enroll your Dependent child(ren) during a previous enrollment period; and
(ii) you are required by a court of administrative order to provide health coverage for your Dependent child; and
(iii) your request for enrollment is made within 31 days after the issue date of the court or administrative order.

The effective date of your Dependent child's coverage will be the first of the calendar month coincident with or next following the date of the request for enrollment.

A copy of the procedures governing qualified medical child support orders (QMCSO) can be obtained from the plan administrator without charge.

b. Continuation due to sickness, injury, temporary layoff, or leave of absence

(1) If you cease to be actively employed because of sickness or injury, your, and your Dependent's, coverage will continue during your sickness or injury until discontinued by the City.

(2) If you cease to be actively employed because of temporary layoff, your, and your Dependent's, coverage will be continued until discontinued by the City, but in no event beyond one month after the last day of the calendar month in which you cease to be actively employed.

(3) If you cease to be actively employed due to an approved leave of absence, your, and your Dependent's, coverage will be continued until discontinued by the City, but in no event beyond six months after the last day of the calendar month in which you cease to be actively employed.

(4) If you are interested in continuing your, and your Dependent's, coverage beyond the date it would normally terminate, you should consult with your employer before your coverage terminates.

c. Deferred Coverage Limits - Applicable to Dental Coverage Only

When your or your Dependent's coverage is subject to these Deferred Coverage Limits, benefits for Covered Charges under Dental Care Parts 2, 3, and 4 will be payable only if treatment or service:

(1) is received after your or your Dependent's coverage has been in force 12 months (Dental Care Parts 2 and 3) or, for your Dependent child(ren), 24 months (Dental Care Part 4); or

(2) is for an Accidental Injury that results from an accident that occurred on or after the effective date of your coverage (Dental Care Parts 2 and 3).

These Deferred Coverage Limits may be removed before they would otherwise expire if proof of your or your Dependent's good dental health is submitted and approved by the Claims Administrator. The Claims Administrator will determine the type and form of required proof. You or your Dependent(s) must pay the cost of obtaining that proof (other than any cost covered by Dental Care Part 1 benefits).

CONTINUATION OF COVERAGE UNDER FEDERAL AND STATE LAW

EARLY RETIREES
(Comprehensive Medical, Optical, Retail and Mail Order Prescription Drugs, and Dental Expense Coverage)

State Required Continuation Under 509A, Code of Iowa

Employees Electing Early Retirement

State law requires that this group plan allow qualified persons who would otherwise lose coverage under the plan as a result of Early Retirement to elect to continue group coverage under the plan.

In administering this state law, the Planholder will apply all benefits and provisions applicable to employees to the Retiree.

If you, as an active Employee, elect an early retirement (before age 65), you and your covered Dependents will be eligible to continue the Comprehensive Medical, Optical, Retail and Mail Order Prescription Drugs, and Dental Expense Coverage described in this booklet, until your attainment of age 65. A "retired employee" is defined as an employee who is receiving a retirement benefit in accordance with Chapters 97B and 411 of the code of Iowa.

If you qualify for both state continuation for retired employees and COBRA continuation, the election of one means the rejection of the other. However, in no instance will the continuation period be less than it would be if COBRA continuation had been elected.

If you are interested in continuing your coverage under this early retirement provision, you should consult with your employer before you retire.

CONTINUATION OF COVERAGE UNDER FEDERAL AND STATE LAW

COBRA CONTINUATION
(Comprehensive Medical, Optical, Retail and Mail Order Prescription Drugs, and Dental Expense Coverage)

Federal Required - Consolidated Omnibus Budget Reconciliation Act (COBRA) - Applies to any employer (excepting the federal government and religious organizations) who: (a) maintains a group health plan; and (b) normally employed 20 or more employees on a typical business day during the preceding calendar year. For this purpose, "employee" means common-law employees (full-time employees and full-time equivalent for part-time employees).

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that your group plan allow qualified persons (described below) to continue group health coverage after it would normally end. The term "group health coverage" includes any medical, dental, vision care, and prescription drug coverages that are included.

A. Qualified Persons/Qualifying Events

Continuation of group health coverage must be offered to:

(1) A Member (and any covered Dependents) following:

(a) termination of employment for a reason other than gross misconduct; or
(b) a reduction in work hours.

(Note: Taking a family or medical leave under the Federal Family & Medical Leave Act (FMLA) is not a qualifying event under COBRA. A Member qualifies for COBRA when the Member does not return to work after completion of FMLA); and

(2) A Member's former spouse (and any Dependent children) following a divorce or legal separation from the Member; and
(3) A Member's surviving spouse (and any Dependent children), following the Member's death; and
(4) A Member's Dependent child following loss of status as a Dependent under the terms of the group plan (e.g., attaining the maximum age, marriage, joining the armed forces, etc.); and
(5) A Member's spouse (and any Dependent children) following the Member's entitlement to Medicare and decision to terminate employment, reduce work hours, or drop group coverage; and
(6) A Member's Dependent child who is born to or placed for adoption with the Member who is on COBRA continuation due to termination of employment or reduction in work hours; and
(7) If the group plan covers retired Members, a retired Member and his/her Dependents (or surviving Dependents) when retired health benefits are "substantially eliminated" or terminated within one year before or after an employer's Chapter 11 (United States Code) bankruptcy proceedings.

Note: Persons who, after the date of COBRA continuation election, become entitled to Medicare or become covered under another group health plan have satisfied the preexisting exclusion provision, are not eligible for continued coverage. However, if the Group Plan covers retired Members, continued coverage for retired persons and their Dependents (or

surviving Dependents) due to qualifying event A (7) above may not be terminated due to Medicare coverage.

B. Qualifying Events/Continuation Period

Following a qualifying event, health coverage can continue up to the maximum continuation period. The maximum continuation period for a Member (and any Dependents) following a termination of employment or reduction in work hours is 18 months. For a Member's Dependent child that is born to or placed for adoption with the Member while on COBRA continuation, the maximum continuation period for that child will be the Member's maximum continuation period.

Following a termination of employment or reduction in work hours, a qualified person may request an 11-month extension of COBRA continuation. The maximum COBRA continuation will be 29 months (see Disabled Extension, Section D).

When a Member becomes entitled to Medicare before employment terminates, work hours are reduced, or a decision to drop coverage, the maximum continuation period for the Dependents will be the longer of:

(1) 36 months dating back to the Member's entitlement to Medicare; or
(2) 18 months from the date of the qualifying event (termination of employment, reduction in work hours, or decision to drop group coverage).

The maximum continuation period for qualified Dependents following a qualifying event described in A (2) through A (4) is 36 months.

If the group plan covers retired Members: For a retired Member on continued coverage under A (7) above (Chapter 11 bankruptcy) the continuation period ends on the date of his/her death. For a retired Member's surviving Dependents, continued coverage ends on the date 36 months after the retired Member dies.

C. Second Qualifying Events/Continuation Period

If during an 18-month continuation period (or, 29 months for qualified persons on the disabled extension), a second qualifying event described in A(2) through A(5) occurs, the maximum continuation period can be extended for the qualified Dependents up to 36 months. That is, following a second qualifying event, qualified Dependents may continue for up to a maximum of 36 months dating from the Member's termination of employment or reduction in work hours. A Member's Dependent child who is born to or placed for adoption with the Member who is on COBRA continuation may also be eligible for a second qualifying event that occurred prior to birth or placement for adoption.

Note: Qualified Dependents must request extended continued coverage within 60 days after a second Qualifying Event occurs.

D. Disabled Extension

Following a termination of employment or reduction in work hours, a qualified person (Member or Dependent) who has been determined disabled by the Social Security Administration either before or within 60 days after a qualifying event may request an extension of the continued coverage from 18 months to 29 months. A Member's Dependent child who is born to or place for adoption with the Member who is on COBRA continuation must be

determined disabled by the Social Security Administration within 60 days after the date of birth or placement for adoption. The disabled extension applies to each qualified person (the disabled person and any family members) who is not disabled, who are entitled to COBRA continuation as a result termination of employment or reduction in work hours.

The qualified person must submit a written request for the extension to the employer (plan administrator) within 60 days after receiving the Social Security determination. If a request for the extension is not made (a) within 60 days after the Social Security disability determination is received; and (b) before the 18-month continuation ends, the right to the 11-month extension expires. The 11-month extension for all qualified persons will end the earlier of (a) 30 days following the date the disabled person is no longer determined by Social Security to be disabled, or (b) the date continuation would normally end as outlined in Section E below.

E. Termination of Continued Coverage

Continued coverage ends the earliest of the following:

(1) The date the maximum continuation period ends; or
(2) The date the qualified person enrolls in Medicare; or
(3) The end of the last coverage period for which payment was made if payment is not made prior to the expiration of the grace period. (See Grace Period, Section I.); or
(4) The date the employer's group health coverage is terminated (and not replaced by another group health plan); or
(5) The date the qualified person becomes covered by and has satisfied the preexisting exclusion provision of another group health plan.

F. Employer Notification Requirement

Qualified persons must be notified of the right to elect continuation of group health coverage within 14 days after a qualifying event. Qualified persons must make written election within 60 days after the later of (1) the date coverage would normally end, or (2) the date of the election notice. The election notice must be returned to the employer within this 60-day period; otherwise the right to elect continuation ends. Persons electing continued coverage have 45 days after the election date to remit the first payment. All remaining payments must be received no later than: (a) 30 days after the first day of each month; or (b) within the 30-day Grace Period (see Grace Period, Section I).

G. Qualified Person Notification Requirement

Qualified persons must notify the employer within 60 days after (a) a divorce or legal separation from the Member, and (b) the date a child ceases to be a Dependent child under the terms of the coverage. Within 14 days following notice by the qualified person of these qualifying events, the employer must provide the qualified person with an election notice. Qualified persons must elect to continue coverage within this 60-day period after receipt of the election notice, otherwise the right to elect ends. Payment must be made within the time limits explained above.

H. Monthly Cost

Persons electing continued coverage can be required to pay 102% of the cost for the applicable coverage (COBRA permits the inclusion of a 2% billing fee). Persons who qualify for the disabled extension and are not part of the family unit that includes the disabled per-

son can be required to continue to pay 102% of the cost for the applicable coverage. Persons who qualify for the disabled extension and are part of the family unit that includes the disabled person can be required to pay 148% of the cost for the applicable coverage (plus a 2% billing fee) for the 19th through the 29th month of coverage (or through the 36th month if a second qualifying event occurs during the disabled extension).

I. Grace Period

"Grace Period" means the first 30-day period following a contribution due date. Except for the first contribution (see Section F), a Grace Period of 30 days will be allowed for payment of contributions. Continued coverage will remain in effect during the Grace Period provided payment is made prior to the expiration of the Grace Period. If payment is not made prior to the expiration of the Grace Period, continued coverage will terminate at the end of the last coverage period for which payment was made.

J. Plan Changes

Continued coverage will be subject to the same benefits and rate changes as the group coverage.

K. Newly Acquired Dependents

A qualified person may elect coverage for a Dependent acquired during COBRA continuation. All enrollment requirements that apply to Dependents of active Members apply to Dependents acquired by qualified persons during COBRA continuation.

Coverage for a newly acquired Dependent will end on the same dates as described for qualified persons in Section B above. Exception: Coverage for newly acquired Dependents, other than the Member's Dependent child who is born to or placed for adoption with the Member, will not be extended as a result of a second qualifying event.

L. Individual Purchase Rights

When a qualified person is no longer eligible for continued coverage, he/she may apply for Individual Purchase. Persons who are eligible for similar benefits which would result in over-coverage may not purchase conversion coverage. An application for Individual Purchase will be provided 180 days prior to the end of the maximum continuation period. Application for Individual Purchase, and payment of the required premium, must be made within 31 days after the continued coverage ends. Dental and Vision Care are not included in the Individual Purchase Rights. Prescriptions Drug are included with the Individual Purchase Rights.

CONTINUATION OF COVERAGE UNDER FEDERAL AND STATE LAW

FEDERAL FAMILY AND MEDICAL LEAVE ACT (FMLA)

(Employee Life and Accidental Death and Dismemberment Insurance, Dependent Life Insurance, Comprehensive Medical, Optical, Retail and Mail Order Prescription Drugs, and Dental Expense Coverage)

Continuation

Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

This is a general summary of the FMLA and how it affects your Group Plan. See your employer for details on this continuation provision including payment provisions.

- **FMLA and Other Continuation Provisions**

  If your employer is an Eligible Employer (as described below) and if the continuation portion of the FMLA applies to your coverage, these FMLA continuation provisions:

  - are in addition to any other continuation provisions of this plan, if any; and
  - will run concurrently with any other continuation provisions of this plan for sickness, injury, layoff, or approved leave of absence, if any.

  If continuation qualifies for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction of the continuation period under both the state and FMLA continuation periods.

- **Eligible Employer**

  Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding Calendar Year.

- **Eligible Employee**

  Eligible Employee means an employee who has worked for the Eligible Employer:

  - for at least 12 months; and
  - for at least 1,250 hours (approximately 24 hours per week) during the year preceding the start of the leave; and
  - at a work-site where the Eligible Employer employs at least 50 employees within a 75-mile radius.

  For this purpose, "employs" has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

- **Mandated Unpaid Leave**

  Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:

  - The birth of a child of an Eligible Employee and in order to care for the child.
  - The placement of a child with the Eligible Employee for adoption or foster care.
  - To care (physical or psychological care) for the spouse, child, or parent of the Eligible Employee, if they have a "serious health condition."
  - A "serious health condition" that makes the Eligible Employee unable to perform the functions of his or her job.

- **Reinstatement**

  An Eligible Employee's terminated coverage may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

  See your employer for details on this reinstatement provision.

CONTINUATION OF COVERAGE UNDER FEDERAL AND STATE LAW

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

(Employee Life and Accidental Death and Dismemberment Insurance, Dependent Life Insurance, Comprehensive Medical, Optical, Retail and Mail Order Prescription Drugs, and Dental Expense Coverage)

Federal law requires that if your coverage would otherwise end because you enter into active military duty, you may elect to continue coverage (including Dependent coverage) in accordance with the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Continuation

If you cease active work because you enter active military duty, coverage may be continued until the earliest of:

- for you and your Dependents:
    - the date the plan is terminated; or
    - the end of the contribution period, if you fail to make timely payment of a required contribution; or
    - the date 18 months after the date you enter active military duty; or
    - the date after the day in which you fail to return to active employment or apply for reemployment with your employer.
- for your Dependents:
    - the date Dependent Comprehensive Medical Expense Coverage would otherwise cease as provided on GH 115/125; or
    - any date desired, if requested by you before that date.

The continuation provision will be in addition to any other continuation provisions described in the plan for sickness, injury, layoff, or approved leave of absence, if any. If you qualify for both state and USERRA continuation, the election of one means the rejection of the other.

Reinstatement

For Comprehensive Medical Expense Coverage, the reinstatement time period may be extended for an approved leave of absence taken in accordance with the provisions of the federal law regarding USERRA.

This is a general summary of the USERRA and how it affects your Group Plan. See your employer for details on this continuation provision.

DESCRIPTION OF BENEFITS

EMPLOYEE LIFE INSURANCE

Death Benefit

If you die while insured for Employee Life Insurance, We will pay your beneficiary the Scheduled Benefit in force on the date of your death, less any Accelerated Benefit payment and Accumulated Interest Charges as discussed later in this Section. If your beneficiary does not survive you, We will pay your estate, spouse, child(ren), parent(s), or other persons as provided in the Group Policy.

Beneficiary

You should name a beneficiary at the time you enroll for insurance. You may later change your beneficiary by filing a written request with your employer. See your employer for change request forms. A change in your beneficiary will not be in force until the Planholder records the change.

Coverage During Disability

If you cease Active Work for any reason, your insurance will normally terminate. However, if you cease Active Work because you are Disabled, you might qualify to continue your Employee Basic and Supplemental Life Insurance. This continuation is called Coverage During Disability.

To be qualified for Coverage During Disability, you must:

- become Disabled while insured for Employee Life Insurance; and
- become Disabled before age 60; and
- remain Disabled continuously; and
- send proof of Disability to Us within one year of the date Disability starts and as often thereafter as We may require; and
- submit to examinations by a Physician when We require (We will pay for these examinations and will choose the Physician); and
- return, without claim, any individual policy issued under your purchase rights as described below.

If you qualify, Coverage During Disability will be in force on the earlier of:

- the day nine months after the date your Disability began; or
- the date of your death.

There will be no Employee Life Insurance premium charge for an Employee while Coverage During Disability is in force.

Coverage During Disability will cease on the earlier of the date you are age 70 or the date you no longer qualify.

If you die while Coverage During Disability is in force, We will pay your beneficiary the Employee Life Insurance benefit, if any, that would have been paid had you remained insured under the benefit schedule in force on the date your Disability began.

Note that Coverage During Disability will not be in force and NO BENEFIT WILL BE PAID if written proof of Disability is not sent to Us within ONE YEAR of the date Disability starts.

Accelerated Benefit

An Accelerated Benefit is an advance (before death) payment of a part of your Employee Life Insurance benefit. To qualify for an Accelerated Benefit, you must:

- be insured for an Employee Life Insurance benefit of at least $20,000; and
- be Terminally Ill (expected to die within 12 months); and
- send proof of your Terminal Illness to Us.

Proof of Terminal Illness will consist of a statement from your Physician, and any other medical information that We believe is needed to confirm your status.

If you qualify, We will pay you any amount you request;

except that:

- only one Accelerated Benefit payment will be made during your lifetime; and
- you must request a payment of at least $10,000; and
- We will not pay you more than the lower of: (1) 50% of your Employee Life Insurance Benefit; or (2) $100,000.

If an Accelerated Benefit is paid, the Employee Life Insurance benefit otherwise payable to your beneficiary upon your death will be reduced by the sum of:

- the Accelerated Benefit payment; plus
- Accumulated Interest Charges.

Accumulated Interest Charges will be the sum of interest charged for each day of the period from the date of your Accelerated Benefit payment to the date of your death. This interest will:

- be calculated by applying a daily rate (equivalent to 8% per year) to the amount of your Accelerated Benefit payment; and
- be limited to a total of not more than 16% of your Accelerated Benefit payment.

During the two-year period following payment of an Accelerated Benefit:

- termination of Active Work because of your Terminal Illness will not result in termination of your Employee Life Insurance; and
- your Employee Life Insurance will be provided without premium charge.

Individual Purchase Rights

You will have the right to buy an individual life insurance policy without submitting proof of your good health:

- If your total Employee Life Insurance terminates because you end Active Work or cease to be in a class eligible for insurance. In these instances, the maximum amount you may buy will be your Employee Life Insurance amount in force on the date of termination, less any individual amount purchased earlier under these rights, and less any Accelerated Benefit and Accumulated Interest Charges as discussed earlier in this Section.

- If the Group Plan terminates or is amended to exclude your insurance class after you have been insured at least five years. In these instances, the maximum amount you may buy will be the smaller of: (1) $2,000; or (2) your Employee Life Insurance amount in force on the date of termination, less any amount for which you become eligible under any group policy within 31 days.

- If your Coverage During Disability ceases because Disability ends and you do not then become insured under the Group Plan within 31 days. In this instance, the maximum amount you may buy will be the benefit amount in force on the date Disability ends, less any individual amount purchased earlier under these rights, and less any Accelerated Benefit and Accumulated Interest Charges as discussed earlier in this Section.

You must apply and pay the first premium for the individual policy within 31 days after the date your Employee Life Insurance or Coverage During Disability ceases. Your individual policy issued will be effective on the 32nd day. See your employer for the proper forms.

The individual policy will be for life insurance only (other than term insurance). No Disability or other benefits will be included. The premium you pay will be at Principal Life Insurance Company's normal rate for your age and for the risk class to which you belong on the individual policy's date of issue.

If you die within the 31-day purchase period, your beneficiary will be paid the life insurance amount, if any, you had the right to buy. This payment will be made whether or not you have applied for an individual policy.

DESCRIPTION OF BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Benefit Qualification

To qualify for benefit payment, all of the following must occur:

- You must be injured while insured for Accidental Death and Dismemberment Insurance.
- Your injury must be through external, violent, and accidental means.
- Your injury must be the direct and sole cause of a loss listed in Benefit Payable below.
- Your loss must occur within 90 days of your injury.
- You must satisfy the requirements listed in the CLAIM PROCEDURES Section.

Benefit Payable

If all of the above qualifications are met, We will pay the following percentages of your Scheduled Benefit (or approved amount, if applicable) in force:

- 50% if one hand is severed at or above the wrist; or
- 50% if one foot is severed at or above the ankle; or
- 50% if the sight of one eye is permanently lost; or
- 100% if more than one of the listed losses occurs; or
- 100% if you lose your life.

Total payment for all losses that result from the same accident will not exceed 100% of your Scheduled Benefit. Payment for loss of life will be to the beneficiary you named for Employee Life Insurance. Payment for all other losses will be to you.

Limitations

Payment will not be made for any loss to which a contributing cause is:

- self-inflicted injury or self-destruction while sane or insane; or
- disease, bodily or mental infirmity, or medical or surgical treatment thereof; or
- insurrection, participation in a riot, police duty as a member of any military, naval, or air organization, war or any act of war declared or undeclared; or
- engaging in or participating in aeronautic operations or activities except as a passenger; or
- participation in the commission or attempted commission of an assault or felony; or

- the taking of or the effects of using any drug, narcotic, or hallucinogen unless prescribed for and administered to you by a Physician; or

- injury arising out of or in the course of any employment for wage or profit.

DESCRIPTION OF BENEFITS

DEPENDENT LIFE INSURANCE

Death Benefit

If one of your Dependents dies while insured for Dependent Life Insurance, We will pay the Scheduled Benefit in force for that Dependent.

Payment will be to you if you survive the Dependent. If not, We will pay the beneficiary you named for Employee Life Insurance.

Individual Purchase Rights

Your spouse will have the right to buy an individual life insurance policy without submitting proof of good health:

- If Dependent Life Insurance for your spouse ceases because you are divorced or separated, or because you die, end Active Work, or cease to be in a class eligible for insurance. In these instances, the maximum amount your spouse may buy will be the amount of Dependent Life Insurance in force for the spouse on the date of termination, less any individual amount purchased earlier under these rights.

- If the Group Policy terminates or is amended to eliminate Dependent Life Insurance or your insurance class after your spouse has been insured for at least five years. In these instances, the maximum amount your spouse may buy will be the smaller of: (1) $1,000; or (2) the spouse's Dependent Life Insurance amount in force on the date of termination, less any amount for which the spouse becomes eligible under any group policy within 31 days.

Your spouse must apply and pay the first premium for the individual policy within 31 days after the date insurance ceases. See your employer for the proper forms. Any individual policy issued will be effective on the 32nd day.

The individual policy will be for life insurance only (other than term insurance). No disability or other benefits will be included. The premium to be paid will be at Our normal rate for your spouse's age and risk class on the individual policy's date of issue.

If your spouse dies within the 31-day purchase period, We will pay the life insurance amount, if any, the spouse had the right to buy. This payment will be made whether or not your spouse has applied for an individual policy.

DESCRIPTION OF BENEFITS

COMPREHENSIVE MEDICAL EXPENSE COVERAGE (PAYMENT PROVISIONS)

Benefit Qualification

To qualify for payment of the benefits provided by your plan for a coverage class, you and your Dependents must:

- be covered in that class on the date medical treatment or service is received; and
- satisfy the requirements listed in the CLAIM PROCEDURES Section.

Benefits Payable

Benefits payable will be as described in this section, subject to:

- all listed limitations; and
- the terms and conditions of COORDINATION WITH OTHER BENEFITS, UTILIZATION MANAGEMENT provisions, and SUBROGATION.

Benefits Payable - Transplant Services

"Transplant Services" means Covered Charges incurred in connection with the Covered Transplants listed below that are for Medically Necessary Care and not considered to be an Experimental or Investigational Measure. The following benefits will be payable for Treatment or Service for Transplant Services. These benefits will be payable instead of any other benefits described in this booklet, unless otherwise indicated below.

Covered Transplants

You or your Dependent will be eligible to receive the following human-to-human organ or bone marrow transplant procedures (including charges for organ or tissue procurement) when it is Medically Necessary Care (which is Generally Accepted and not considered Experimental or Investigational Measures at the time the required predetermination of benefits for the transplant is completed). The transplant procedures will be subject to all limitations and maximums described in this section.

- Heart;
- Heart/lung (simultaneous);
- Lung;
- Liver;
- Kidney;
- Pancreas;
- Kidney/Pancreas (simultaneous);
- Bone marrow transplant or peripheral stem cell infusion when a positive response to standard medical treatment or chemotherapy has been documented. Coverage is for one transplant or infusion only within a 12-month period.

Cornea and skin transplants are not Covered Transplants for the purpose of this section. Instead, cornea and skin transplants are covered under the normal provisions of this Comprehensive Medical section, and are not subject to any conditions set forth in this section.

Covered Charges

Transplant Services Covered Charges will include all services listed in the general Comprehensive Medical Covered Charges section, including, but not limited to, services by a Home Health Care Agency, Skilled Nursing Facility, or Hospice.

Covered Charges will include cryopreservation and storage of bone marrow or peripheral stem cells when the cryopreservation and storage is part of a protocol of high dose chemotherapy, which has been determined by the Claims Administrator to be Medically Necessary Care, not to exceed $10,000 per approved transplant.

Covered Charges will also include charges incurred by the organ donor for a Covered Transplant if the charges are not covered by any other medical expense coverage.

Within the Transplant Network

For Transplant Services provided by a Transplant Network Provider, benefits payable for Treatment or Service received each calendar year will be paid at the PPO level of benefits.

If transplant related services are provided by a Transplant Network Provider, travel and lodging expenses for the patient and a travel companion will be covered if the treating facility is greater than 150 miles one way from the patient's home (excluding travel or lodging provided by a family member or friend). This would include ambulance expenses that would otherwise be excluded under the Comprehensive Medical ambulance benefit. Benefits payable cannot be used to satisfy any Deductible or Copayment amount under the ambulance benefit in the normal provisions of the Comprehensive Medical section.

Travel and lodging benefits will be payable at 100% without application of any Deductible amount, up to a maximum benefit of $10,000 for each approved transplant.

Limitations Within and Outside the Transplant Network

The general Comprehensive Medical limitations listed in this section will apply to Transplant Services. In addition, benefits will not be payable for:

- cryopreservation and storage, except as described above under Covered Charges; or
- if the transplant is not a Covered Transplant under this Plan, all charges related to the transplant will be excluded from payment under this Plan, including, but not limited to, dose-intensive chemotherapy; or
- animal-to-human organ transplants; or
- implantation within the human body of artificial or mechanical devices designed to replace human organ(s).

Limitations specific to Home Health Care**,** Skilled Nursing Facility Confinement, and Hospice Care provisions will apply to Transplant Services if those benefits are used in connection with a Covered Transplant.

For each transplant episode Covered Charges will be limited to:

- transplant evaluations from no more than two transplant providers; and
- no more than one listing with the United Network of Organ Sharing (UNOS).

Benefits paid for Transplant Services will be applied to the Comprehensive Medical Overall Lifetime Maximum Payment Limit and this maximum will be reduced by the benefits paid.

Benefits Payable - Pediatric Vaccines

Subject to the benefits payable provisions as described above, benefits will be payable for:

Pediatric Vaccines

Covered Charges will include the cost of Pediatric Vaccines administered to a Dependent child from birth through 18 years of age.

"Pediatric Vaccines" mean those vaccines shown on the list established and periodically reviewed by the Advisory Committee on Immunization Practices as referenced by Section 1928 of Title 19 of the Social Security Act or such other list of vaccines as mandated by other Federal or State laws that are applicable to this plan.

Benefits for Pediatric Vaccines will be paid at 100% of Prevailing Charges and no Deductible will be applied.

Benefits Payable - Well-Child Care

Subject to the benefits payable provisions described above, benefit will be payable for Well-Child Care. Covered Charges will include charges for Well-Child Care from birth to age seven as described below:

Definition

Well-Child care services include, at a minimum, a history and complete physical examination, as well as developmental assessment, anticipatory guidance, immunizations, vision and hearing screening, and laboratory services including, but not limited to, screening for lead exposure as well as blood levels. Developmental assessment and anticipatory guidance mean the services described in the Guidelines for Health Supervision II, published by the American Academy of Pediatrics.

Covered Services Limitations

For the purposes of these benefits, Well-Child Care will be limited to one visit to one provider for each covered Dependent child at approximately the following age intervals: birth, two weeks, two months, four months, six months, nine months, 12 months, 15 months 18 months, 24 months or two years, four years, five years, and six years, for any or all of the covered services provided at each visit.

Rate of Payment

Benefits will be payable on the same basis as for all other Physician office visits except that no Deductible will be applied.

Benefits Payable - Maternity Coverage

Covered Charges will include Hospital Confinement Charges incurred by a mother and newborn Dependent child. Benefits will be payable for a minimum of 48 hours following a vaginal delivery and a minimum of 96 hours following a cesarean section, excluding the day of delivery. Benefits will be payable the same as for any other covered treatment or service; however, the 48-hour and 96-hour minimum will not be subject to the Hospital Admission Review or Medically Necessary Care requirements of this Plan. Any benefits payable in excess of the 48-hour or 96-hour minimum will be subject to all terms and conditions of the plan document that apply to any other treatment or service.

It should be noted that the covered individual and her Physician may agree that a shorter stay than the above minimums is appropriate. In such cases, benefits will be payable for the actual time that the person is hospitalized.

Benefits Payable - Mental or Nervous Disorders, Alcoholism, or Drug Abuse

The following benefits will be payable for confinement, treatment or service due to mental or nervous disorders, alcoholism, or drug abuse. These benefits will be payable instead of any other benefits described in this booklet.

Inpatient Hospital Services

If you or one of your Dependents is confined in a Hospital for 23 or more consecutive hours due to a mental or nervous disorder, alcoholism, or drug abuse, benefits will be payable for charges by the Hospital for room, board, and other usual services and for Physician Visits provided during such confinement.

Benefits will be payable the same as for any other sickness for not more than 30 days of confinement each Calendar Year for each covered person.

Benefits will be payable for Physician Visits when provided while the person is Hospital confined, only if they occur during the period for which these inpatient Hospital benefits are payable.

Outpatient Services

If you or one of your Dependents receives treatment or service on an outpatient basis due to a mental or nervous disorder, alcoholism, or drug abuse, benefits will be payable for Covered Charges incurred for such treatment or service.

"Outpatient Services" means treatment or service (including Physician office/clinic Visit charges) which is provided other than while confined in a Hospital for 23 or more consecutive hours.

For the purpose of the benefits described above:

- no benefits will be payable for any charges incurred in excess of the limits and maximums described; and

- for Covered Charges incurred at a facility other than a Hospital, benefits will be payable the same as for any other sickness for outpatient laboratory services and for outpatient drugs and medicines requiring a Physician's prescription.

- charges incurred for Outpatient Treatment of a mental or nervous disorder, alcoholism, or drug abuse, that are in excess of those charges approved by the Claims Administrator for such Outpatient Treatment (including, but not limited to, excesses in Prevailing Charges, and/or Calendar Year, and Lifetime Maximums) will not be considered Covered Charges; and

- for Outpatient Treatment of a mental or nervous disorder, alcoholism, or drug abuse, benefits payable for charges incurred for such treatment will be reduced by $300 per occurrence unless the Cost Containment Requirements described on page GH 102 are satisfied.

In addition, benefits payable for medical care received from a PPO Provider or from a Non-PPO Provider will be combined and applied toward the limits and maximums described above under the heading Mental or Nervous Disorder, Alcoholism, or Drug Abuse.

Benefits Payable – Women's Health and Cancer Rights Act of 1998

Under federal law, group health plans and health insurance issuers providing benefits for a mastectomy must also provide, in connection with the mastectomy for which the participant or beneficiary is receiving benefits, coverage for:

- reconstruction of the breast on which the mastectomy has been performed;

- surgery and reconstruction of the other breast to produce a symmetrical appearance;

- prostheses and physical complications of mastectomy, including lymphedemas;

in a manner determined in consultation between the attending Physician and the patient.

These benefits may be subject to annual Deductibles and Copay provisions that are appropriate and consistent with other benefits under the plan or coverage.

DESCRIPTION OF BENEFITS

COMPREHENSIVE MEDICAL EXPENSE COVERAGE

Payment Conditions

If you or one of your Dependents receives treatment or service for a sickness or injury, the Plan-holder will pay Medical benefits for Covered Charges:

- in excess of any Deductible and/or Copay amounts; and
- at the payment percentage(s) indicated; and
- to the Maximum Payment Limit;

as described in the SUMMARY OF BENEFITS Section.

Covered Charges Carried Forward

To determine Deductible satisfaction, treatment or service received by you or by a Dependent during the last three months of a calendar year may be counted as if received in either:

- the calendar year in which actually received; or
- the next following calendar year;

whichever would result in greater benefit payment.

Covered Charges

Covered Charges will be the actual cost charged to you or one of your Dependents for Medically Necessary Care, but only to the extent that the actual cost charged does not exceed Prevailing Charges for:

- Hospital room and board (but not more than the Hospital Room Maximum if confinement is in a private room);
- Hospital services other than room and board;
- Birthing Center services; and
- Ambulatory Surgery Center services; and
- the services of a Physician, including surgery and Physician Visits; and
- charges for the services of a Health Care Extender;
- the services of a licensed practical nurse or a graduate registered nurse, but only when such services are provided during confinement in a Hospital or Skilled Nursing Facility, or when such services are provided as a part of Home Health Care or Hospice Care, or as otherwise required by state law; and

- physical, occupational, and speech therapy; and

- drugs and medicines requiring a Physician's prescription (including birth control pills and excluding those charges paid under Retail and Mail Order Prescription Drugs Expense Coverage); and

- surgical dressings, casts, splints, braces, crutches, artificial limbs, and artificial eyes; and

- Durable Medical Equipment, including repair, adjustment, or replacement of purchased Durable Medical Equipment, unless damage results from your or your Dependent's negligence or abuse of such equipment. Covered Charges will not include charges which are in excess of the purchase price of the equipment; and

- anesthesia, blood, blood plasma, and oxygen; and

- x-ray and laboratory examinations; and

- x-ray, radium, and radioactive isotope therapy; and

- charges for sterilizations (including vasectomies) and mammogram services;

- the surgical removal of impacted teeth when performed by a Dentist, in the Dentist's office or clinic; and

- charges for services furnished at a Physician's clinic or office or at your home or your Dependent's home. Such services include charges for dressings, supplies, equipment, injections, anesthesia, take-home drugs; blood, blood plasma, x-ray and laboratory examinations, x-ray, radium, and radioactive isotope therapy, routine physical examinations, sterilizations (including vasectomies), pap smears, and mammogram services;

- charges for Pediatric Vaccines, as described on pages GH 400;

- charges for Well-Child Care, as described on GH 402-1;

- charges for disposable supplies related to dialysis treatment while provided in a Physician's office or clinic, but only for 12 months during any one person's lifetime;

- charges for diabetic outpatient, self-management education if provided by a certified program in a Physician's office or clinic;

- Dental Services at a Dentist's office to repair damage to the jaw and natural teeth, if the damage is the direct result of an accident (but did not result from chewing) and if the Dental Services are completed within six months after the accident;

- charges for transportation by ambulance provided by a Hospital or a licensed service to and from a local Hospital (or to and from the nearest Hospital equipped to furnish needed treatment not available in a local Hospital);

- convalescent care in a Nursing Facility as described in this section;

- Home Health Care as described in this section;

- Hospice Care as described in this section.

Covered Charges will also include utilization management services by the Claims Administrator, to utilize a more cost effective Generally Accepted form of Medically Necessary Care, when compared to use of covered expenses contained in this plan.

Prevailing Charges for Multiple Surgical Procedures

If you or one of your Dependents undergoes two or more procedures during the same anesthesia period, Covered Charges for the services of the Physician, facility, or other covered provider for each procedure that is clearly identified and defined as a separate procedure will be based on:

- 100% of Prevailing Charges for the first or primary operation; and

- 50% of Prevailing Charges for each of the other operations.

Covered Charges for an Assistant during Surgical Procedures

Benefits will be payable for the services of an assistant to a surgeon if such services are determined by the Claims Administrator to be Medically Necessary Care. An assistant to a surgeon is considered to be Medically Necessary Care if the skill level of an M.D. or D.O. would be required to assist the primary surgeon. Covered Charges for such services will be paid at up to 20% of Prevailing Charges of the covered surgical procedure if the procedure is performed by a Physician or a Health Care Extender.

In addition, the multiple surgical procedures percentiles, as described above will be applied.

Home Health Care

Comprehensive Medical Covered Charges will include charges by a Home Health Care Agency for:

- part-time or intermittent home nursing care by or under the supervision of a registered nurse; and

- part-time or intermittent home care by a Home Health Aide which consist primarily of caring for the individual; and

- physical, occupational, or speech therapy; and

- drugs and medicines (requiring a Physician's prescription) and other supplies prescribed by the attending Physician, if the cost of these items would have been Covered Charges had you or your Dependent remained Hospital confined; and

- laboratory services by or for a Hospital if the cost of these services would have been Covered Charges had you or your Dependent remained Hospital confined;

but only to the extent that such services and supplies are provided under the terms of a Home Health Care Plan and treatment or service begins within seven days after Hospital Inpatient Confinement ceases.

The general Comprehensive Medical limitations listed in this section will apply to Home Health Care. In addition, Comprehensive Medical Covered Charges will not include charges for:

- services or supplies not included in the Home Health Care Plan; or

- the services of any person who normally lives in your home or your Dependent's home; or

- Custodial Care; or

- transportation services; or

- more than 100 Home Health Care visits in a Calendar Year. For this purpose, one visit will be counted for up to four hours of service (in a 24-hour period) by a Home Health Aide and one visit will be counted for each visit by any other person.

Hospice Care

Comprehensive Medical Covered Charges will include charges for Hospice Care Services provided by a Hospice, Hospice Care Team, Hospital, Home Health Care Agency, or Nursing Facility for:

- any sick or injured individual (you or any one of your Dependents) who, in the opinion of the attending Physician, has no reasonable prospect of cure and is expected to live no longer than six months; and

- the family (you or any one of your Dependents) of any such individual;

but only to the extent that such Hospice Care Services are provided under the terms of a Hospice Care Program and are billed through the Hospice that manages that program.

Hospice Care Services consist of:

- inpatient and outpatient care, home care, nursing care, counseling, and other supportive services and supplies provided to meet the physical, psychological, spiritual, and social needs of the dying individual; and

- drugs and medicines (requiring a Physician's prescription) and other supplies prescribed for the dying individual by any Physician who is a part of the Hospice Care Team; and

- instructions for care of the patient, counseling, and other supportive services for the family of the dying individual.

The general Comprehensive Medical limitations listed in this section will apply to Hospice Care. In addition, Comprehensive Medical Covered Charges will not include Hospice Care charges that:

- exceed $10,000 for any one Episode of Hospice Care; or

- are for Hospice Care Services not approved by the attending Physician and the Claims Administrator; or

- are for transportation services; or

- are for Custodial Care; or

- are for Hospice Care Services provided at a time other than during an Episode of Hospice Care.

Nursing Facility Confinement

Comprehensive Medical Covered Charges will include charges by a Nursing Facility for room, board and other services required for treatment, provided the confinement:

- is certified by a Physician as necessary for recovery from a sickness or injury; and
- requires skilled nursing services.

Covered room and board charges for each day will be not more than 50% of:

- the actual room charge (if Hospital confinement was in a semi-private room); or
- the Hospital Room Maximum (if the Hospital confinement was in a private room);

of the Hospital in which you or your Dependent was confined before the Skilled Nursing Facility confinement. If you or your Dependent were not confined immediately prior to admission to the Skilled Nursing Facility, this will be calculated based on the room rate of the most recent Hospital confinement within the past 90 days. If you or your Dependent have not been Hospital confined during this period, the room rate will be based on the room rate at the Hospital your Physician would have admitted you to for this sickness or injury if hospitalization had been required.

Covered charges will not include:

- charges for more than 120 days for all Skilled Nursing Facility confinements that result from the same or a related sickness or injury; or
- charges incurred for a Skilled Nursing Facility confinement after the date the attending Physician stops treatment or withdraws certification.

Limitations

Comprehensive Medical Covered Charges will not include and no benefits will be paid for:

- Treatment or Service that is not for Medically Necessary Care; or
- any part of a charge for Treatment or Service that exceeds Prevailing Charges; or
- the services of any person in your Immediate Family or any person in your Dependent's Immediate Family; or
- Dental Services and materials (except as described under Covered Charges); eye examinations for the correction of vision or the fitting of glasses (except as described under Well-Child Care); vision materials (frames or lenses); hearing aids; acupuncture or acupressure treatment; drugs or medicines that do not require a Physician's prescription; vitamins, minerals, nutritional supplements or special diets (whether they require a Physician's prescription or not); wigs or hair prostheses; and comfort or convenience services and supplies; or
- Treatment or Service due to any form of temporomandibular joint disorder (malfunction, degeneration, or disease related to the joint that connects the jaw to the skull), including but not limited to braces, splints, appliances, or surgery of any type; or

- Treatment or Service for Cosmetic Procedures and Services or complications arising therefrom, unless the procedure or service results from a sickness or an accidental injury which occurs while you or your Dependent claiming benefits is covered under this plan, and unless the procedure or service is completed within 12 months after the date of that sickness or injury; or

- Treatment or Service for educational or training problems, learning disorders, marital counseling, or social counseling (except as provided under Hospice Care); or

- Treatment or Service for which you or your Dependent has no financial liability or that would be provided at no charge in the absence of coverage; or

- Treatment or Service that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or

- Treatment or Service that results from war or act of war or from voluntary participation in criminal activities; or

- Treatment or Service for Kerato-Refractive Eye Surgery for myopia (nearsightedness), hyperopia (farsightedness), or astigmatism; or

- charges for telephone calls and/or telephone consultations; or

- Treatment or Service that results from a sickness that is covered by a Workers' Compensation Act or other similar law; or

- Treatment or Service that results from an injury arising out of or in the course of any employment for wage or profit; or

- Treatment or Service related to the restoration of fertility or the promotion of conception (including reversal of voluntary sterilization); or

- charges or expenses related to audiological evaluations; or

- Treatment or Service by any type of health care practitioner not otherwise provided for in this plan, unless recognition is state mandated; or

- Treatment or Service provided outside the United States, unless you or your Dependent is outside the United States for one of the following reasons:

    - travel, provided the travel is for a reason other than securing health care diagnosis or treatment; or
    - a business assignment; or
    - you are employed by the Planholder outside the United States; or
    - Full-Time Student status, provided your Dependent is either:

        - enrolled and attending an accredited school in a foreign country; or
        - is participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit.

COMPREHENSIVE MEDICAL EXPENSE COVERAGE

UTILIZATION REVIEW

Notice of Utilization Review

For purposes of satisfying the claims processing requirements, receipt of claim will be considered to be met when the Cost Containment Administrator receives Notification of Utilization Review Services. The Cost Containment Administrator may request additional information to substantiate the loss or require a signed unaltered authorization to obtain that information from the provider. Failure to comply with the Cost Containment Administrator's request could result in declination of Utilization Review services.

If you, your Dependent, or designated patient representative fails to follow the Cost Containment Administrator's procedures for filing a claim for a Hospital Admission Review, a Prospective Review or an Urgent Review, the Cost Containment Administrator will notify you, your Dependent, or designated patient representative of the failure and the proper procedures to be followed.

Utilization Management Requirements - Non-PPO Provider

Benefits payable for Hospital Inpatient Confinement Charges and Surgery Related Charges will be reduced by $300 per occurrence unless:

- For Hospital Inpatient Confinement Charges, a Hospital Admission Review is requested from the Cost Containment Administrator by you, a Dependent, or a designated patient representative as soon as a Hospital Inpatient Confinement is scheduled, but no later than the day of a Hospital Inpatient Confinement, for other than a Medical Emergency; and for a Medical Emergency within two business days of a Hospital Inpatient Confinement.

  If a Hospital Admission Review is not requested in a timely manner as specified above, the $300 reduction in benefits payable will be applied to all Hospital Inpatient Confinement Charges, but only to the charges incurred up to the date a Hospital Admission Review is obtained.

  Benefits will be payable only for that part of the Hospital Inpatient Confinement Charges the Cost Containment Administrator determines to be Medically Necessary Care.

  Certain exceptions apply to Hospital Inpatient Confinement for childbirth as described below.

- For all charges incurred for services listed below under Pretreatment Review, a Pretreatment Review is requested from the Cost Containment Administrator by you, your Dependent, or a designated patient representative as soon as the service is scheduled but no later than the day the service begins or is continued, unless it is demonstrated that a Medical Emergency existed.

  Benefits will be payable only for services the Cost Containment Administrator determines to be Medically Necessary Care.

The $300 reduction in Benefits Payable is a penalty for failure to comply with any of the Utilization Management Requirements listed. The reduction will not count toward satisfaction of the Out-of-Pocket Expense limits described in the Summary of Benefits section.

Hospital Admission Review - Non-PPO Providers

A Hospital Admission Review by the Cost Containment Administrator is required for all Hospital Inpatient Confinements (scheduled or emergency).

The following exception applies to Hospital Inpatient Confinement for childbirth.

> Medically Necessary Care requirements are waived and a Hospital Admission Review is not required for mother and baby, for:
>
> - A 48-hour Hospital Inpatient Confinement following vaginal delivery; or
> - A 96-hour Hospital Inpatient Confinement following cesarean section.
>
> A request for review by the Cost Containment Administrator of the need for continued Hospital Inpatient Confinement for mother or baby beyond the automatically approved time period stated above must be made by you, a Dependent, or a designated patient representative before the end of that time period.

If you, a Dependent, or a designated patient representative fail to request a Hospital Admission Review as specified in this section, benefits will be reduced as described above. Exception: For all Hospital Inpatient Confinement Charges incurred beyond the 48-hour or 96-hour automatically approved Hospital Inpatient Confinement for childbirth, the penalty will be applied beginning the date the automatically approved time period ends. **Except as waived above, no benefits will be payable for any Treatment or Service that is not for Medically Necessary Care.**

For the purpose of these requirements, "Hospital Admission Review" means review by the Cost Containment Administrator of a Physician's report of the need for a Hospital Inpatient Confinement, scheduled or emergency, (unless it is for an automatically approved Hospital Inpatient Confinement for childbirth).

The report (verbal or written) must include the:

- reason(s) for the Hospital Inpatient Confinement; and
- significant symptoms, physical findings, and treatment plan; and
- procedures performed or to be performed during the Hospital Inpatient Confinement; and
- estimated length of the Hospital Inpatient Confinement.

If a Hospital Inpatient Confinement will exceed the approved number of days, the Cost Containment Administrator will initiate a Continued Stay Review. For the purpose of these requirements, "Continued Stay Review" means a review by the Cost Containment Administrator of a Physician's report of the need for continued Hospital Inpatient Confinement.

The report (verbal or written) must include the:

- reason(s) for requesting continued Hospital Inpatient Confinement; and
- significant symptoms, physical findings, and treatment plan; and
- procedures performed or to be performed during the Hospital Inpatient Confinement; and
- estimated length of the continued Hospital Inpatient Confinement.

Pretreatment Review - Non-PPO Provider

A Pretreatment Review by the Cost Containment Administrator is required for the services listed below.

If you, a Dependent, or a designated patient representative fail to request a Pretreatment Review as soon as the service is scheduled, but no later than the day the service begins or continues, benefits will be reduced as described in this section, unless it is demonstrated that a Medical Emergency existed. **No benefits will be payable for any Treatment or Service that is not for Medically Necessary Care.**

Conditions and Procedures

CARDIOVASCULAR CONDITIONS

- Carotid endarterectomy
- Coronary angiography
- Coronary artery bypass surgery
- Heart transplant
- Heart-lung transplant

GASTROINTESTINAL CONDITIONS

- Cholecystectomy
- Colonoscopy
- Gastric surgery for obesity
- Hemorrhoidectomy
- Lipectomy
- Liver transplant
- Pancreas transplant
- Upper gastrointestinal endoscopy

GYNECOLOGIC CONDITIONS

- Dilation/curettage
- Hysterectomy
- Laparoscopy
- Mammoplasty

MENTAL/NERVOUS, ALCOHOLISM/DRUG ABUSE CONDITIONS

Outpatient Treatment

Two initial visits are allowed prior to review. After the second visit, a Pretreatment Review Authorization must be requested for future visits.

OPHTHALMOLOGIC CONDITIONS

- Blepharoplasty
- Cataract extraction
- Radial keratotomy
- Strabismus repair

ORTHOPEDIC CONDITIONS

- Bunionectomy
- Carpal tunnel release
- Jaw surgery
- Hammertoe repair
- Knee arthroscopy
- Laminectomy
- Manipulation
- Spinal fusion

OTOLARYNGOLOGIC CONDITIONS

- Adenoidectomy
- Allergy shots
- Bronchoscopy
- Rhinoplasty
- Septoplasty
- Tonsillectomy
- Tympanotomy tube insertion

URINARY CONDITIONS

- Cystoscopy

MISCELLANEOUS DIAGNOSTICS AND TREATMENTS

- Computerized tomographic scan spine
- Radioallergosorbent test

For the purpose of these requirements, a "Pretreatment Review" means a review by the Cost Containment Administrator of a Physician's report of a proposed service on the Pretreatment Review list, unless the service is a Medical Emergency.

The report (verbal or written) must include the:

- reason(s) for the proposed service; and
- significant symptoms, physical findings, treatment history, and proposed treatment plan.

Utilization Review Program - For PPO and Non-PPO Providers

- **Prospective Review**

  For an initial Prospective Review, a decision will be made within two business days of the date the Cost Containment Administrator receives all the necessary information needed to complete the review or within 15 calendar days of the date the Cost Containment Administrator receives Notification of Utilization Review services, whichever time period is earlier. If a determination cannot be made due to insufficient information, the Cost Containment Administrator will provide an explanation of the information needed to complete the review. You, the patient, the attending Physician or other Ordering Provider or the facility rendering the service is permitted up to 45 calendar days to provide the necessary information. The Cost Containment Administrator will render a decision within two business days of either receiving the necessary information or upon the expiration of 45 calendar days, the Cost Containment Administrator will render a decision within 15 calendar days, if no additional information is received. If the Cost Containment Administrator certifies a health care service, notification will be provided promptly by telephone, facsimile, or in writing to the attending Physician or other Ordering Provider, the facility rendering service, and you or the patient. Written notification will be sent within two business days of the determination. For Noncertifications, notification will be made to the attending Physician or other Ordering Provider or facility rendering service by telephone within one business day and written notification will be sent within one business day, with notice also sent to you or the patient.

- **Urgent Review**

  For an Urgent Review, a review decision will be made within 72 hours of the date the Cost Containment Administrator receives Notification of Utilization Review Services. If a determination cannot be made due to insufficient information, the Cost Containment Administrator will provide an explanation of the information needed to complete the review. You, the patient, the attending Physician or other Ordering Provider or the facility rendering the service is permitted up to 48 hours to provide the necessary information. The Cost Containment Administrator will render a decision within 48 hours of either receiving the necessary information or if no additional information is received, the expiration of the 48 hours to provide the specified additional information.

- **Concurrent Review**

  For a Concurrent Review, a review decision will be made within one business day of the date the Cost Containment Administrator receives all necessary information needed to complete the review or prior to the end of the current certified period. If the Cost Containment Administrator certifies a health care service, notification will be provided promptly either by telephone, facsimile, or in writing to the attending Physician or other Ordering Provider, the facility rendering service, and you or the patient within one business day of receipt of all information necessary to complete the review. For Noncertifi-

cations, notification will be made to the attending Physician or other Ordering Provider or facility rendering service by telephone within one business day and written notification sent within one business day, with notice also sent to you or the patient.

- **Retrospective Review**

  For a Retrospective Review, a determination will be made within 30 calendar days after the date the Cost Containment Administrator receives Notification of Utilization Review Services. If a determination cannot be made due to insufficient information, the Cost Containment Administrator will provide an explanation of the information needed to complete the review. You, the patient, the attending Physician or other Ordering Provider or the facility rendering the service is permitted up to 45 calendar days to provide the necessary information. The Cost Containment Administrator will render a decision within 15 calendar days of either receiving the necessary information or the expiration of 45 calendar days, if no additional information is received. Written notification will be sent to the attending Physician or other Ordering Provider, the facility rendering service, and you or the patient within two business days of the determination (but not later than 30 calendar days from receipt of Notification of Utilization Review Services. For Noncertifications, notification will be made to you, the patient, attending Physician or other Ordering Provider or facility rendering service in writing within one business day (but not later than 30 calendar days from receipt of Notification of Utilization Review Services).

- **Request for Reconsideration**

  When an initial determination is made not to certify an admission or other service and no peer-to-peer conversation has occurred, the Peer Clinical Reviewer that made the initial decision will be made available within one business day to discuss the Noncertification decision with the attending Physician or other Ordering Provider upon their request. If the original Peer Clinical Reviewer is not available, another Peer Clinical Reviewer will be made available to discuss the review.

  At the time of the conversation, if the reconsideration process is unable to resolve the difference of opinion regarding a decision not to certify, the attending Physician or other Ordering Provider will be informed of their right to initiate an appeal and the procedure to do so.

- **Appeal of Noncertifications**

  You, your Dependent, a designated patient representative, Physician or other health care provider has the right to request two appeal review*s* of any utilization management determination, by telephone, fax, or in writing. The Claims Administrator will make a full and fair review of the Noncertification. The first level of appeal review must be completed before filing a civil action or pursuing any other legal remedies.

- **Expedited Appeal Review and Voluntary Appeal Review**

  An Expedited Appeal is a request, usually by telephone but can be written, for an additional review of a determination not to certify imminent or ongoing services and an appeal of an Urgent Review. An Expedited Appeal Review must be requested within 180 calendar days of the receipt of a Noncertification. To resolve the expedited appeal, maximum information will be shared by telephone, fax, or in writing. A Peer Clinical Reviewer who did not make the original determination, is not a subordinate

of the Peer Clinical Reviewer who made the original determination and who is in the same or similar specialty as the attending Physician or other Ordering Provider will conduct the review.

A determination on the expedited appeal of an imminent or ongoing service will be made within one business day of receiving the necessary information needed to complete the appeal review or within 30 calendar days from request of an expedited appeal review. Notification of the appeal review outcome will be made by telephone to the attending Physician or other Ordering Provider with written notification sent to you or the patient, the attending Physician or other Ordering Provider within two business days of an expedited appeal of an initial review and within one business day of an expedited appeal of a Concurrent Review or declination.

A determination on the expedited appeal of an Urgent Review decision will be made within 72 hours from request of an expedited appeal review.

If the Noncertification is affirmed on the appeal review, you, the patient, attending Physician or other Ordering Provider can request a voluntary appeal. The appeal may be requested by telephone, fax, or in writing. You, the patient, attending Physician or other Ordering Provider may submit written comments, documents, records, and other information relating to the request for appeal. The Claims Administrator will make a determination within 30 calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, the Claims Administrator will send a written explanation of the additional information that is required or an authorization for you or the patient's signature so information can be obtained from the attending Physician or other Ordering Provider. This information must be sent to the Claims Administrator within 45 calendar days of the date of the written request for the information. Failure to comply with the request for additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 30 calendar days of the receipt of all necessary information to properly review the appeal request.

Election of a second appeal is voluntary and does not negate your right or the patient's right to bring civil action following notification of the decision rendered during the expedited appeal, nor does it have any effect on your rights or the patient's rights to any other benefit under the group plan. The voluntary appeal process is offered in an effort that the claim may be resolved in good faith without legal intervention. At anytime during the second appeal process, you or the patient may file a civil action or pursue any other legal remedies.

Note: The expedited appeal process does not apply to Retrospective Reviews.

- **Standard Appeal Review and Voluntary Appeal Review**

A standard appeal may be requested either in writing or verbally. It must be requested within 180 calendar days of the receipt of a Noncertification. To complete the standard appeal process, it may be necessary for the Claims Administrator to request a statement from the attending Physician or other Ordering Provider and request all or part of the medical records. A Peer Clinical Reviewer who was not involved in the prior review, is not a subordinate of the Peer Clinical Reviewer who made the original determination and who is in the same or similar specialty as the attending Physician or other Ordering Provider will conduct the review. A determination will be made within 30 calendar days of receiving the request for an appeal review.

Notification will be made in writing to you or the patient, the attending Physician or other Ordering Provider within two business days (but not later than 30 calendar days from receiving the request for an appeal review).

If the Noncertification is affirmed on the appeal review, you, the patient, attending Physician or other Ordering Provider can request a voluntary appeal. The appeal may be requested by telephone, fax, or in writing. You, the patient, attending Physician or other Ordering Provider may submit written comments, documents, records, and other information relating to the request for appeal. A determination will be made within 30 calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, a written explanation will be sent of the additional information that is required or an authorization for your or the patient's signature so information can be obtained from the attending Physician or other Ordering Provider. This information must be sent to the Claims Administrator within 45 calendar days of the date of the written request for the information. Failure to comply with the request for additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 30 calendar days of the receipt of all necessary information to properly review the appeal request.

Election of a second appeal is voluntary and does not negate your right or the patient's right to bring civil action following notification of the decision rendered during the standard appeal, nor does it have any effect on your rights or the patient's rights to any other benefit under the group plan. The voluntary appeal process is offered in an effort that the claim may be resolved in good faith without legal intervention. At anytime during the second appeal process, you or the patient may file a civil action or pursue any other legal remedies.

SEE THE CLAIMS PROCEDURES SECTION OF THIS BOOKLET FOR IMPORTANT CLAIM PROCEDURES INFORMATION ON FILING YOUR MEDICAL CLAIMS.

DESCRIPTION OF BENEFITS

OPTICAL EXPENSE COVERAGE

Payment Conditions

If you or one of your Dependents undergoes a Complete Visual Analysis or purchases any of the listed vision aids, the Claims Administrator will pay the provider's charges to the Maximum Payment Limits as described in the SUMMARY OF BENEFITS Section.

Complete Visual Analysis

The term "complete visual analysis" means refraction and eye examination including case history, examination for disease or pathological abnormalities of eyes and lids, ranges of clear single vision and balance and coordination of muscles for far seeing, near seeing, special working distances analysis, and professional consultation.

Limitations

Optical benefits will not be paid for:

- a visual analysis or vision aids that are not for Medically Necessary Care; or
- any part of a charge for a visual analysis or vision aids that exceed Prevailing Charges; or
- a visual analysis performed by other than a Physician or Optometrist, or vision aids not prescribed by a Physician or Optometrist; or
- a visual analysis or vision aids provided by any person in your Immediate Family or any person in your Dependent's Immediate Family; or
- a visual analysis or vision aids provided as the result of a sickness that is covered by a Workers' Compensation Act or other similar law; or
- a visual analysis or vision aids provided as the result of an injury arising out of or in the course of any employment for wage or profit; or
- a visual analysis or vision aids for which you or your Dependent has no financial liability or that would be provided at no charge in the absence of coverage or that is paid by the United States Government or one of its agencies (except as provided under Medicaid provisions or Federal law); or
- duplication or replacement of lenses or frames which have been lost, stolen, or broken; or
- sunglasses (prescribed or not); or
- more than one Complete Visual Analysis in any period of 12 consecutive months; or
- more than two lenses (one pair) in any period of 12 consecutive months or more than one set of frames in any period of 24 consecutive months; or

- a visual analysis or vision aids provided as the result of war or act of war or voluntary participation in criminal activities.

DESCRIPTION OF BENEFITS

RETAIL PRESCRIPTION DRUGS EXPENSE COVERAGE

Payment Conditions

If drugs and medicines are prescribed to treat you or one of your Dependents, the Planholder will pay Prescription Drugs benefits for Covered Charges:

- in excess of the Copay amount; and
- at the payment percentage indicated;

as described in the SUMMARY OF BENEFITS Section.

Benefit payment will be restricted to:

- Covered Charges as described below; and
- the greater of a 34-day supply or a 100-unit dose for each prescription and each refill.

Covered Charges

Covered Charges will be the actual cost charged to you or one of your Dependents for:

- Diabetic care: Disposable insulin needles/syringes and insulin; and
- Depo-Provera up to a 90-day supply; and
- contraceptives; and
- non-injectable Legend drugs (except as described under Limitations) and any other drug or medicine that can be legally dispensed only upon the written prescription of a Physician;

but only to the extent that the actual cost charged does not exceed Prevailing Charges.

For certain drugs and classes of drugs designated by the Claims Administrator, the Claims Administrator reserves the right to:

- require prior authorization for dispensing; and
- limit quantities whose cost will be deemed to be Covered Charges.

To request a preauthorization, contact the Pharmacy Benefit Manager at the telephone number listed on your or your Dependent's identification card.

Limitations

Prescription Drugs Covered Charges will not include and no benefits will be paid for:

- drugs or medicines that are not for Medically Necessary Care; or

- any part of a charge for drugs or medicines that exceeds Prevailing Charges; or

- drugs or medicines dispensed by a Hospital, Nursing Facility, rest home, or other institution in which you or one of your Dependents is confined; or

- drugs or medicines delivered or administered by the prescriber; or

- drugs or medicines prescribed or dispensed by any person in your Immediate Family or any person in your Dependent's Immediate Family; or

- drugs or medicines (other than insulin) that can be purchased without a Physician's prescription; or

- vitamins (including prescription prenatal drugs), minerals, and nutritional supplements; or

- dietary supplements; or

- therapeutic devices or appliances, including hypodermic needles, support garments, and other nonmedicinal substances, regardless of intended use; or

- administration of any drug or medicine; or

- infertility drugs, immunization agents, blood or blood plasma; or

- injectable drugs; or

- P-Ephed Sul/Loratadine; or

- any prescription or refill in excess of the number directed by the Physician or any refill dispensed more than one year after the prescription date; or

- drugs or medicines for which you or your Dependent has no financial liability or that would be provided at no charge in the absence of coverage; or

- drugs or medicines that are paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or

- drugs or medicines provided as the result of a sickness or injury that is due to war or act of war or to voluntary participation in criminal activities; or

- drugs or medicines provided as the result of a sickness that is covered by a Workers' Compensation Act or other similar law; or

- drugs or medicines provided as the result of an injury arising out of or in the course of any employment for wage or profit; or

- growth hormones; or

- cosmetic hair removal products; or

- hair growth stimulants; or

- health and beauty aids; or

- drugs labeled "Caution—limited by Federal law to investigational use", or experimental, even though a charge is made to the individual; or

- dermatologicals used for cosmetic purposes; or

- DESI drugs (drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness; or

- Nicorette gum or any other drug containing nicotine or other smoking deterrent medication; or

- anorectics (any drug used for the purpose of weight control) or

- Alosetron HCI (e.g. Lotronex); or

- Levonorgestrel (Norplant); or

- Loratadine; or

- diabetic supplies (other than as described under Covered Charges); or

- Pigmenting/Depigmenting agents. Exception: Methoxsalen (e.g. Oxsoralen), Methoxsalen-rapid (e.g. Oxsoralen-Ultra) and Trioxsalen (e.g. Trisoralen) are covered.

- fluoride tablets, topical dental fluorides; or

- progesterone, all dosage forms.

Payment, Denial, and Review

To file a claim for benefits when utilizing a Member Pharmacy, contact the Pharmacy Benefit Manager at the telephone number listed on your or your Dependent's identification card. To file a claim for benefits when utilizing a Nonmember Pharmacy or when an identification card is not utilized at a Member Pharmacy, submit a prescription drug claim form to the Pharmacy Benefit Manager.

Written proof of loss must be sent to the Pharmacy Benefit Manager within 90 calendar days after the date of loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when the Pharmacy Benefit Manager receives proof of loss. Proof of loss includes the patient's name, your name (if different from the patient's name), prescription drug name and date prescription drug dispensed. The Pharmacy Benefit Manager may request additional information to substantiate the loss or require a signed unaltered authorization to obtain that information from the provider. Failure to comply with the Pharmacy Benefit Manager's request could result in declination of the claim.

Up to 30 calendar days from receipt of claim is permitted for processing the claim. If a claim cannot be processed due to incomplete information, the Pharmacy Benefit Manager will send a written explanation prior to the expiration of the 30 calendar days. The claimant is then allowed up to 45 calendar days to provide all additional information requested. The Pharmacy Benefit

Manager will render a decision within 15 calendar days of either receiving the necessary information or upon the expiration of 45 calendar days if no additional information is received.

In actual practice, benefits under the group plan may be payable sooner, provided the Pharmacy Benefit Manager receives complete and proper proof of loss. If a claim is not payable or cannot be processed, the Pharmacy Benefit Manager will submit a detailed explanation of the basis for the denial.

A claimant may request an appeal of a claim denial by written request to the Claims Administrator within 180 calendar days of receipt of notice of the denial. The Claims Administrator will make a full and fair review of the claim. The Claims Administrator may require additional information to make the review. The Claims Administrator will notify the claimant in writing of the appeal decision within 60 calendar days of receiving the appeal request. The first level of appeal review must be completed before filing a civil action or pursuing any other legal remedies.

After exhaustion of the formal appeal process, a claimant may request a voluntary appeal. The appeal must be requested in writing. The claimant may submit written comments, documents, records, and other information relating to the claim for benefits. The Claims Administrator will make a determination within 60 calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, the Claims Administrator will send a written explanation of the additional information that is required or an authorization for the claimant's signature so information can be obtained from the provider. This information must be sent to the Claims Administrator within 45 calendar days of the date of the written request for the information. Failure to comply with the request for additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 60 calendar days of the receipt of all necessary information to properly review the appeal request.

Election of a second appeal is voluntary and does not negate the claimant's right to bring civil action following the first appeal, nor does it have any effect on the claimant's right to any other benefit under the group plan. The voluntary appeal process is offered in an effort that the claim may be resolved in good faith without legal intervention. At anytime during the voluntary appeal process, the claimant may file a civil action or pursue any other legal remedies.

If a prescription drug is not covered under Prescription Drug Expense Coverage, it may be submitted for consideration under Medical Expense Coverage.

For purposes of this section, "claimant" means you or your Dependent.

DESCRIPTION OF BENEFITS

MAIL ORDER MAINTENANCE PRESCRIPTION DRUGS EXPENSE COVERAGE

Payment Conditions

If Maintenance Drugs and Medicines are prescribed to treat you or one of your Dependents, the Planholder will pay Mail Order Maintenance Drugs benefits for Covered Charges:

- in excess of the Copay amount; and
- at the payment percentage indicated;

as described in the SUMMARY OF BENEFITS Section.

Maintenance Drugs and Medicines are those taken on a regular or long term basis to treat such conditions as high blood pressure, ulcers, arthritis, heart or thyroid conditions, emphysema or diabetes, etc.

Benefit payment will be restricted to:

- prescribed maintenance medications which are necessary to treat a chronic or long-term sickness or injury; and
- Diabetic care: Disposable insulin needles/syringes and insulin; and
- contraceptives; and
- non-injectable Legend drugs (except as described under Limitations) and any other drug or medicine that can be legally dispensed only upon the written prescription of a Physician; and
- up to a 90-day supply for each prescription and each refill; and
- prescriptions that are filled through the pharmacy designated to administer the prescription drugs program.

For certain drugs and classes of drugs designated by the Claims Administrator, the Claims Administrator reserves the right to:

- require prior authorization for dispensing; and
- limit quantities whose cost will be deemed to be Covered Charges.

To request a preauthorization, contact the Pharmacy Benefit Manager at the telephone number listed on your or your Dependent's identification card.

Mail Order Pharmacy

The Planholder has contracted with AdvancePCS, a state-of-the-art mail service pharmacy to administer this program.

Brand Name Versus Generic Name

Many maintenance drugs come in two forms, brand name and generic. Both brand name and generic drugs are covered under the program.

The pharmacy will automatically fill your prescription with a generic drug (if available) if the prescribing Physician has indicated that a generic substitution is acceptable. If the prescribing Physician indicates that generic substitution is not acceptable (even though available), the pharmacy will use the brand name drug.

90-Day Supplies

Typically, prescriptions submitted to the pharmacy will be filled in up to 90-day supplies. Please have your Physician contact the pharmacy at the toll-free number shown on your order form if there are any questions.

How to Order From the Pharmacy

Your initial order consists of three parts: the written prescription from your Physician; a Patient/Profile Order form with preaddressed envelope; and a Copay. These are described below. You should allow 14 days for your order to be completed and shipped to you. All orders are mailed either by Federal Express or First Class U.S. Mail.

The Written Prescription

When obtaining your prescription, be sure to ask your Physician to specify the following information:

- patient name;
- up to a 90-day supply of medication (the Physician should indicate the total number of pills required for that period of time. For example, 270 tablets would be needed for medication that must be taken three times a day.);
- refills (many maintenance drugs can be prescribed for up to one year; therefore, a prescription for up to a 90-day supply may specify up to three refills.);
- Physician's signature.

Also it is very important to include your name, address, and social security number on the prescription form, so that eligibility for the program can be verified when the pharmacy receives the order.

Patient Profile/Order Form

Included in the installation package you receive, as well as with each order shipped, is the Patient Profile/Order Form. This form is to be completed and sent to the pharmacy with each order. The Patient Profile/Order Form provides information concerning eligibility in addition to health and allergy conditions pertaining to each covered person.

Copay

A check or money order for the correct amount of Copay must accompany each order. The Copay amount is described in the SUMMARY OF BENEFITS Section. You may also be able to charge your Copay as explained on the Patient Profile/Order Form.

Refills or Follow-up Orders

Each filled order you receive includes Refill Ordering Instructions, a Patient/Profile Order Form, and a preaddressed envelope. Orders for refills should be placed approximately two weeks before the current supply or medication is expected to run out.

Special Situations

If a maintenance medication is prescribed for immediate use, you should obtain two prescriptions--one for a 14-day supply to be filled immediately at a local pharmacy, and a second for up to a 90-day supply with refills, to be filled by AdvancePCS.

If a maintenance medication is prescribed on a trial basis, you should obtain two prescriptions: one for a limited supply, to be filled immediately at a local pharmacy, and a second for up to a 90-day supply with refills, to be filled by AdvancePCS if and when the medication proves satisfactory.

Questions

If you have a question concerning medication or a particular order, you can call the pharmacy customer service. The toll-free number is shown on your order forms.

Also included with each order filled by AdvancePCS is a Patient Counseling information sheet which has specific information about the medication included with the order.

Limitations

Certain drugs and medications are not covered by the program, including, but not limited to:

- drugs or medicines that are not for Medically Necessary Care; or
- drugs or medicines that are not for the treatment of a chronic or long-term illness; or
- any part of a charge for drugs or medicines that exceeds Prevailing Charges; or
- drugs or medicines dispensed by a Hospital, Nursing Facility, rest home, or other institution in which you or one of your Dependents is confined; or
- drugs or medicines delivered or administered by the prescriber; or
- drugs or medicines prescribed or dispensed by any person in your Immediate Family or any person in your Dependent's Immediate Family; or
- drugs or medicines (other than insulin) that can be purchased without a Physician's prescription; or

- vitamins (including prescription prenatal drugs), minerals, and nutritional supplements; or

- dietary supplements; or

- therapeutic devices or appliances, including hypodermic needles, support garments, and other nonmedicinal substances, regardless of intended use; or

- administration of any drug or medicine; or

- infertility drugs, immunization agents, blood or blood plasma; or

- injectable drugs; or

- P-Ephed Sul/Loratadine; or

- any prescription or refill in excess of the number directed by the Physician or any refill dispensed more than one year after the prescription date; or

- drugs or medicines for which you or your Dependent has no financial liability or that would be provided at no charge in the absence of coverage; or

- drugs or medicines that are paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or

- drugs or medicines provided as the result of a sickness or injury that is due to war or act of war or to voluntary participation in criminal activities; or

- drugs or medicines provided as the result of a sickness that is covered by a Workers' Compensation Act or other similar law; or

- drugs or medicines provided as the result of an injury arising out of or in the course of any employment for wage or profit; or

- growth hormones; or

- cosmetic hair removal products; or

- hair growth stimulants; or

- health and beauty aids; or

- drugs labeled “Caution—limited by Federal law to investigational use”, or experimental, even though a charge is made to the individual; or

- dermatologicals used for cosmetic purposes; or

- DESI drugs (drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness; or

- Nicorette gum or any other drug containing nicotine or other smoking deterrent medication; or

- anorectics (any drug used for the purpose of weight control) or
- Alosetron HCI (e.g. Lotronex); or
- Levonorgestrel (Norplant); or
- Loratadine; or
- diabetic supplies (other than as described under Covered Charges); or
- Pigmenting/Depigmenting agents. Exception: Methoxsalen (e.g. Oxsoralen), Methoxsalen-rapid (e.g. Oxsoralen-Ultra) and Trioxsalen (e.g. Trisoralen) are covered.

Payment, Denial and Review

To file a claim for benefits, when utilizing a pharmacy designated to provide mail service, contact the Pharmacy Benefit Manager at the telephone number listed on your or your Dependent's identification card.

Written proof of loss must be sent to the Pharmacy Benefit Manager within 90 calendar days after the date of loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when the Pharmacy Benefit Manager receives proof of loss. Proof of loss includes the patient's name, your name (if different from the patient's name), prescription drug name and date prescription drug dispensed. The Pharmacy Benefit Manager may request additional information to substantiate the loss or require a signed unaltered authorization to obtain that information from the provider. Failure to comply with the Pharmacy Benefit Manager's request could result in declination of the claim.

Up to 30 calendar days from receipt of claim is permitted for processing the claim. If a claim cannot be processed due to incomplete information, the Pharmacy Benefit Manager will send a written explanation prior to the expiration of the 30 calendar days. The claimant is then allowed up to 45 calendar days to provide all additional information requested. The Pharmacy Benefit Manager will render a decision within 15 calendar days of either receiving the necessary information or upon the expiration of 45 calendar days if no additional information is received.

In actual practice, benefits under the group plan may be payable sooner, provided the Pharmacy Benefit Manager receives complete and proper proof of loss. If a claim is not payable or cannot be processed, the Pharmacy Benefit Manager will submit a detailed explanation of the basis for the denial.

A claimant may request an appeal of a claim denial by written request to the Claims Administrator within 180 calendar days of receipt of notice of the denial. The Claims Administrator will make a full and fair review of the claim. The Claims Administrator may require additional information to make the review. The Claims Administrator will notify the claimant in writing of the appeal decision within 60 calendar days of receiving the appeal request. The first level of appeal review must be completed before filing a civil action or pursuing any other legal remedies.

After exhaustion of the formal appeal process, a claimant may request a voluntary appeal. The appeal must be requested in writing. The claimant may submit written comments, documents, records, and other information relating to the claim for benefits. The Claims Administrator will make a determination within 60 calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, the Claims Administrator will send a written explanation of the additional information that is required or an authorization for the claimant's sig-

nature so information can be obtained from the provider. This information must be sent to the Claims Administrator within 45 calendar days of the date of the written request for the information. Failure to comply with the request for additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 60 calendar days of the receipt of all necessary information to properly review the appeal request.

Election of a second appeal is voluntary and does not negate the claimant's right to bring civil action following the first appeal, nor does it have any effect on the claimant's right to any other benefit under the group plan. The voluntary appeal process is offered in an effort that the claim may be resolved in good faith without legal intervention. At anytime during the voluntary appeal process, the claimant may file a civil action or pursue any other legal remedies.

If a prescription drug is not covered under Mail Order Maintenance Prescription Drug Expense Coverage, it may be submitted for consideration under Medical Expense Coverage.

For purposes of this section, "claimant" means you or your Dependent.

DESCRIPTION OF BENEFITS

INDIVIDUAL PURCHASE PRIVILEGE
(Employees and Dependents)

If your Medical Expense Coverage terminates, you may buy other medical expense coverage from a designated insurance carrier. Except that, you may not buy other medical expense coverage if your Medical Expense Coverage terminates because:

- you failed to pay any required contribution; or

- the Group Plan terminates and continuous coverage is provided under a replacement group medical expense plan.

A statement of health will not be required. The other coverage will be on one of the forms the designated insurance carrier then issues to persons who apply for individual purchase.

The persons to be covered under the other medical expense coverage will be you and all of your Dependents who are covered under the Group Plan on the date coverage ceases, except that any Developmentally Disabled or Physically Handicapped child beyond the maximum age for Dependent children will be covered provided in the last paragraph.

The designated insurance carrier will not issue other medical expense coverage if you are covered by similar coverage which, together with this coverage, may result in overinsurance based on the designated insurance carrier's standards for overinsurance.

You must apply for individual purchase and pay the first premium to the designated insurance carrier within 31 days after your coverage under the Group Plan is terminated. All terms of the program will be instituted by your designated carrier. Please see your Benefits Manager for details.

Your spouse may buy other medical expense coverage in the same manner described above for you, if coverage under the Group Plan ceases for your spouse because:

- of your death; or

- of divorce or legal separation.

A child may also buy other medical expense coverage in the same manner as described above for you, if coverage under the Group Plan ceases for the child because the child is no longer eligible as a Dependent.

A child beyond the maximum age for Dependent children, who is incapable of self-support because of a Developmental Disability or Physical Handicap may also buy other medical expense coverage in the same manner as described above for you, if the child's coverage under the Group Plan ceases because your coverage terminates as described above.

NOTE: Individual purchase is also available at the end of any continuation period, provided the person is not then covered for similar coverage which, together with this coverage, would result in overinsurance, based on the conversion carrier's standards for overinsurance.

DESCRIPTION OF BENEFITS

DENTAL EXPENSE COVERAGE - PAYMENT PROVISIONS

Benefit Qualification

To qualify for payment of the benefits provided by your plan for a coverage class, you must:

- be covered in that class on the date dental treatment or service is received; and
- satisfy the requirements listed in the CLAIM PROCEDURES Section; and
- file a Dental Treatment Plan with the Claims Administrator before treatment begins when charges for a Period of Dental Treatment (other than Emergency Treatment) are expected to exceed **$200**. A form is available for this purpose. The Claims Administrator will indicate the benefits payable for the proposed treatment and return the form to the attending Dentist.; and

Benefits Payable

Benefits payable will be as described in this section, subject to:

- all listed limitations; and
- the terms and conditions of COORDINATION WITH OTHER BENEFITS Section.

DESCRIPTION OF BENEFITS

DENTAL EXPENSE COVERAGE

Payment Conditions

If you or one of your Dependents receives any treatment or service that is listed in the Schedule of Dental Procedures, the Claims Administrator will pay Dental benefits for Covered Charges:

- in excess of the Deductible amount(s); and
- at the payment percentage(s) indicated; and
- to the Maximum Allowances (indicated in the Schedule of Dental Procedures) and Maximum Payment Limits;

as described in the SUMMARY OF BENEFITS Section.

Covered Charges

Covered Charges will be the actual cost charged to you or your Dependent for treatment or service, but not more than the Maximum Allowances shown in the Schedule of Dental Procedures. Also:

- If the Claims Administrator determines that more than one procedure could be performed to correct a dental condition, Covered Charges will be limited to the Maximum Allowance for the least expensive of the procedures that would provide professionally acceptable results.
- Covered Charges will include only those charges for treatment or service that begins (see below) while you and your Dependents are covered under this plan.
- Covered Charges will include only those charges for treatment or service that is completed while you and your Dependents are covered under the plan (except when the treatment or service is covered under the Extended Benefits provision).

Beginning Date for Treatment or Service

Treatment or service will be considered to begin:

- for root canal therapy, on the date the pulp chamber is opened and the pulp canal explored to the apex; and
- for crowns, fixed bridgework, inlays, or onlay restoration, on the date the tooth or teeth are fully prepared; and
- for full or partial dentures, on the date the master impression is made; and
- for orthodontia, on the date the appliances or bands are first set; and
- for all other, on the date the treatment or service is performed.

A temporary dental treatment will be considered an integral part of the final treatment rather than a separate treatment.

Limitations

Dental Covered Charges will not include and no benefits will be paid for:

- treatment, service, or material that is not for Necessary Dental Care; or
- any part of a charge for treatment or service that exceeds Prevailing Charges; or
- the services of any person who is not a Dentist or Dental Hygienist; or
- the services of any person in your Immediate Family or any person in your Dependent's Immediate Family; or
- any instructions for plaque control, oral hygiene, or diet control; or
- any treatment or service which does not have uniform professional endorsement, including (but not limited to) implants or other experimental procedures; or
- any treatment or service primarily for cosmetic purposes, including (but not limited to) personalization or characterization of dentures and facings on crowns or pontics posterior to the second bicuspid; or
- drugs and medicines (other than antibiotic injections); or
- treatment or service to alter or maintain vertical dimension or restore occlusion; or
- treatment or service to duplicate or replace a lost or stolen prosthetic device or to duplicate or replace a lost or stolen appliance; or
- orthodontic treatment, service, appliance, or bands received within 12 months after your Dependent child's Dental Expense Coverage is effective, unless the appliance or bands were first inserted on or after the effective date; or
- treatment or service for which you or your Dependent has no financial liability or that would be provided at no charge in the absence of coverage; or
- treatment or service that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or
- treatment or service that results from war or act of war; or
- treatment or service that results from voluntary participation in criminal activities; or
- treatment or service that is covered by a Workers' Compensation Act or other similar law; or
- treatment or service that results from an injury arising out of or in the course of any employment for wage or profit.

Schedule of Dental Procedures

Covered Charges will include only charges for procedures listed in the Schedule of Dental Procedures. If a nonlisted procedure is accepted, the Claims Administrator will determine its Maximum Allowance based on the Maximum Allowance for a listed procedure of comparable nature.

Subject to the terms and conditions described under Payment Conditions in this section, the Maximum Allowance for each procedure described on the following pages will be the actual cost charged, but only to the extent that the actual cost charged does not exceed Prevailing Charges, Calendar Year Maximums and Lifetime Maximums as shown in the SUMMARY Section.

DESCRIPTION OF BENEFITS

SCHEDULE OF DENTAL PROCEDURES

Dental Care Part 1 - Diagnostic and Preventive Services

Examinations

Oral examination

Only one oral examination (other than emergency examination) will be covered each six-month period.

Radiographs

Intraoral x-rays (complete series)

Covered once each three-year period.

Bitewing

Only one set will be covered each six-month period.

Occlusal
Periapical

Extraoral x-rays

Panoramic
Sialography
TMJ
Cephalometric film
Posterior/anterior and lateral skull and facial bone survey
Other extraoral

Only one of the listed extraoral procedures will be covered each six- month period.

Diagnostic x-rays performed in conjunction with root canal therapy or orthodontic treatment will not be considered Part 1 Covered Charges.

Preventive Services

Prophylaxis (cleaning of teeth including scaling and polishing)

Covered once each six- month period.

Topical application of fluoride

Applicable only to Dependent children. Only one application will be covered each 12-month period.

Space maintainers

Applicable only to Dependent children under age 14.

Topical application of sealants

Applicable only to Dependent children under age 14. Covered once each quadrant in each four-year period.

Other Services

Biopsy of oral tissue
Palliative treatment

Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

Bacteriologic culture
Histopathologic examinations
Pulp vitality test
Diagnostic cast

Covered once each two-year period.

Dental Care Part 2 - Basic Restoration Services

Restorations

Fillings (amalgam, silicate, plastic or composite, including pin retention when necessary)

Stainless steel crown

Oral Surgery

Extraction of teeth
Alveoloplasty
Removal of dental cysts and tumors
Incision and drainage of dental abscess
Tooth replantation
Surgical exposure to aid eruption
Surgical repositioning of teeth
Excision of hyperplastic tissue

Periodontic Services

Scaling and root planing (each quadrant)

Covered once each quadrant each six-month period.

Periodontal appliance

One appliance is covered in each three-year period.

Periodontal prophylaxis

Gingivectomy
Gingival curettage
Osseous surgery
Osseous graft

Only one of these procedures is covered per quadrant each 12-month period.

Endodontic Services

Pulp cap
Pulpotomy
Root canal therapy

including treatment plan, diagnostic x-rays, clinical procedures and follow-up care

Apicoectomy and retrograde fillings

Covered as a separate procedure only if performed more than one year after the root canal therapy is completed

Endodontic Services (continued)

Apexification
Apical curettage
Root resection
Hemisection

Anesthesia

General anesthesia

Covered as a separate procedure only when required for complex oral surgical procedures covered under this plan and only when not performed in a Hospital.

Other Services

Repairs to bridges and full or partial dentures

Relining dentures

Covered only if relining is done more than one year after the initial installation and then not more than once each two-year period.

Recementing bridges, inlays, crowns and space maintainers
Adding additional teeth to partial denture
Consultation with specialist
Antibiotic drug injection

Dental Care Part 3 - Major Restoration Services

All procedures listed include one year of follow-up care.

Restorations

Gold foil
Gold inlays and onlays

Gold restorations are covered only if the tooth cannot be restored by a silver filling and (for replacements) at least five years have elapsed since the last placement.

Porcelain inlays

Crowns - Single Restorations

Plastic or porcelain crowns (with gold, semiprecious metal or nonprecious metal)

Full cast crowns (gold, semiprecious metal, or nonprecious metal)

Crowns are covered only if the tooth cannot be restored by a filling, and (for replacements) at least five years have elapsed since the last placement. Crowns for the primary purpose of periodontal splinting, altering vertical dimension or restoring vertical occlusion are not covered.

Cast post and core

Covered only for teeth that have had root canal therapy

Steel post and composite or amalgam

Prosthodontics - Fixed

Fixed bridges

Initial placement/Replacement

Initial placement of fixed bridges or full or partial dentures to replace teeth which were missing prior to the effective date of the individual's coverage will be covered only after the individual has been covered under this plan for 24 consecutive months, unless the bridge or denture also includes replacement of a natural tooth extracted while covered. Replacement of fixed bridges is covered only if the original bridge cannot be made serviceable and (a) the person has been covered under this plan for at least 12 consecutive months; and (b) at least five years have elapsed since the last placement.

Prosthodontics - Removable

Full or partial dentures

Initial placement/Replacement

Initial placement of full or partial dentures to replace teeth which were missing prior the effective date of the person's coverage will be covered only after the person has been covered under the plan for 24 consecutive months, unless the dentures also includes replacement of a natural tooth extracted while covered. Replacement of full or partial dentures is covered only if the existing denture cannot be made serviceable and (a) the person has been covered under this plan for at least 12 consecutive months (not applicable if replacement of a denture is made necessary by the initial placement of an opposing full denture); and (b) at least five years have elapsed since the last placement. Covered Charges for removable prosthodontics do not include any additional charges for overdentures or for precision or semi-precision attachments.

Dental Care Part 4 - Orthodontia - For Dependent Children Only

Comprehensive Orthodontic Treatment:

a. Fixed appliances, including x-rays and other diagnostic procedures--formal, full-banded treatment and retention.

b. Removable appliances, including x-rays and other diagnostic procedures, and retention.

c. Appliances for tooth guidance, removable and fixed.

d. Appliances for control of oral habits harmful to dental health, removable and fixed.

e. Retention appliances, removable and fixed.

DESCRIPTION OF BENEFITS

EXTENDED BENEFITS
(After Termination of Coverage-Dental)

If Dental Expense Coverage under your plan ceases and if you or your Dependents qualify, the Planholder will pay for:

- root canal therapy, but only if the pulp chamber was opened and the pulp canal explored to the apex while you or a Dependent was covered under this plan; and

- crowns, bridges, inlays or onlay restorations, but only if the tooth or teeth were fully prepared while you or a Dependent was covered under this plan; and

- full or partial dentures, but only if the master impression was made while you or a Dependent was covered under this plan; and

- orthodontia, but only if the appliance or bands were first set while the Dependent child was covered under this plan. The amount payable will be the part of the quarterly payment that would have been payable had coverage remained in force during the period extended benefits are payable;

provided the treatment or service is received within the lesser of two months or the duration of the treatment plan.

You or a Dependent will qualify if:

- you or a Dependent would have qualified for benefit payment under this plan had coverage remained in force; and

- the treatment or service began while you or a Dependent was covered under this plan; and

- this plan is in force at the time treatment or service is received.

However, no Extended Benefits will be paid for treatment or service received on or after the date you or your Dependents become eligible for other group dental expense coverage.

COORDINATION WITH OTHER BENEFITS

COMPREHENSIVE MEDICAL, OPTICAL, AND DENTAL EXPENSE COVERAGES

Intent

The intent of Coordination with Other Benefits is to provide that the sum of benefits paid under This Plan (except for Retail and Mail Order Prescription Drugs Expense Coverages) plus benefits paid under all other Plans will not exceed the actual cost charged for a treatment or service.

Definitions

As used in this section the term This Plan will mean the medical, optical, and dental expense benefits described in this booklet.

The term Plan will mean This Plan and any medical or dental expense benefits provided under:

- any insured or noninsured group, service, prepayment, or other program arranged through an employer, trustee, union, or association; and

- any program required or established by state or Federal law (including Medicare Parts A and B); and

- any program sponsored by or arranged through a school or other educational agency.

The term Plan will not include benefits provided under a student accident policy (elementary through high school), nor will the term Plan include benefits provided under a state medical assistance program where eligibility is based on financial need.

Also, the term Plan will apply separately to those parts of any program that contain provisions for coordination of benefits with other Plans and separately to those parts of any program which do not contain such provisions.

The terms Primary Plan/Secondary Plan means the order of benefit determination rules determine whether This Plan is a "Primary Plan" or a "Secondary Plan" when compared to another Plan covering the person. When this Plan is Primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is Secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.

The term Allowable Expense will mean all Prevailing Charges for treatment or service when at least a part of those charges are covered under at least one of the Plans then in force for the person for whom benefits are claimed. However, the difference between the cost of a private room and the cost of a semiprivate room will be an Allowable Expense only when confinement in a private room is Medically Necessary Care. If a Plan provides benefits in a form other than cash payments, the cash value of those benefits will be both an Allowable Expense and a benefit paid.

The term Claim Determination Period will mean the part of a Calendar Year during which you or a Dependent would receive benefit payments under This Plan if this section were not in force.

Effect on Benefits

Benefits otherwise payable under This Plan for Allowable Expenses during a Claim Determination Period may be reduced if:

- benefits are payable under any other Plan for the same Allowable Expenses; and

- the rules listed below provide that benefits payable under the other Plan are to be determined before the benefits payable under This Plan.

The reduction will be the amount needed to provide that the sum of payments under This Plan plus benefits payable under the other Plan(s) is not more than the total of Allowable Expenses. Each benefit that would be payable in the absence of this section will be reduced proportionately; any such reduced amount will be charged against any applicable benefit limit of This Plan.

For this purpose, benefits payable under other Plans will include the benefits that would have been paid had you submitted a claim for them. Also, for any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B, whether or not the person is covered under that Part B.

Order of Benefit Determination

Except as described under Medicare Exception below, the benefits payable of a Plan that does not have a coordination of benefits provision similar to the provision described in this section will be determined before the benefits payable of a Plan that does have such a provision. In all other instances, the order of determination will be:

- Nondependent/Dependent. The benefits of a Plan which covers the person for whom benefits are claimed as an employee, member, or subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent.

- Dependent Child--Parents Not Separated or Divorced. When this Plan and another Plan cover the same child as a Dependent of different persons called "parents," the benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that year; but if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

  However, if another Plan does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- Dependent Child--Separated or Divorced Parents. If two or more Plans cover a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

  - first, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child; and
  - finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply for any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules for Dependent children of parents who are not separated or divorced.

- Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid-off nor retired, or as that employee's Dependent, are determined before the benefits of a Plan which covers that person as a laid-off or retired employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- Continuation of Coverage. If coverage is provided for a person under a right of continuation according to Federal or state law and the person is also covered under another Plan, the following will be the order of benefit determination:

  - First, the benefits of a Plan covering the person as an employee, Member or subscriber (or as that person's dependent);
  - Second, the benefits under the continuation coverage.

  If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- Longer/Shorter Length of Coverage**.** If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member, or subscriber for whom benefits are claimed longer are determined before those of the Plan which covered that person for the shorter time.

Medicare Exception

Unless otherwise required by Federal law, benefits payable under Medicare will be determined before the benefits payable under This Plan.

Exchange of Information

Any person who claims benefits under This Plan must, upon request, provide all information that is needed to coordinate benefits.

In addition, all information that is needed to coordinate benefits may be exchanged with other companies, organizations, or persons.

Facility of Payment

The Planholder may reimburse any other Plan if:

- benefits were paid by that other Plan; but

- should have been paid under This Plan in accordance with this section.

In such instances, the reimbursement amounts will be considered benefits paid under This Plan and, to the extent of those amounts, will discharge This Plan from liability.

Right of Recovery

If it is determined that benefits paid under This Plan should have been paid under any other Plan, This Plan will have the right to recover those payments from:

- the person to or for whom the benefits were paid; and/or

- the other companies or organizations liable for the benefit payments.

SUBROGATION

(Comprehensive Medical Expense Coverage)

Applicability

This section will apply if you or one of your Dependents:

- receives benefit payment under this Plan as the result of a sickness or injury; and
- has a lawful claim against another party or parties or insurer (including uninsured, underinsured, and no-fault automobile insurers) for compensation, damages, or other payment because of that same sickness or injury.

The Planholder will have the right of first reimbursement from any recovery you or one of your Dependents receives even if you or one of your Dependents has not been made whole.

Transfer of Rights

In those instances where this section applies, the rights of you or one of your Dependents to claim or receive compensation, damages, or other payment from the other party or parties will be transferred to the Planholder, but only to the extent of benefit payments made under this Plan.

Member and Dependent Obligations

To secure the rights of the Planholder under this section, you or one of your Dependents must:

- Complete any applications or other instruments and provide any documents the Planholder might require, and cooperate with the Planholder and its agents in order to protect the subrogation rights of this Plan.
- If payment from the other party or parties has been received, reimburse the Planholder for benefit payment made under this Plan (but not more than the amount paid by the other party or parties).
- You and/or your Dependents will not take any action that prejudices the rights of this Plan. If you and/or your Dependents enter into litigation or settlement negotiations regarding obligations of other parties, you and/or your Dependents must not prejudice, in any way, the subrogation rights of the Plan.

The costs of legal representation retained by the Planholder in matters related to subrogation will be borne solely by the Planholder. The costs of legal representation retained by you and/or your Dependents will be borne solely by you or your Dependents.

CLAIM PROCEDURES

Claim Forms

Except in the case of medical care received from Preferred Providers, claim forms and other information needed to prove loss must be filed with the Plan administrator in order to obtain payment of plan benefits. The Planholder will provide forms and other filing assistance. If forms are not provided within 15 calendar days after the Planholder receives such notice of claim, you will be considered to have complied with the requirements of the group plan regarding proof of loss upon submitting, within the time specified below for filing proof of loss, written proof covering the occurrence, character, and extent of the loss.

When you become covered, you will be issued an identification card. This card should be presented to each provider at the time you or a Dependent receive needed medical care. The Cost Containment Administrator will assist you with the Hospital Admission Review and Pretreatment Review requirements in accordance with the terms of your plan.

Proof of Loss

Completed claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to the Claim Administrator within 90 calendar days after the date of loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when we receive proof of loss. Proof of loss includes the patient's name, your name (if different from patient's name), provider of services, dates of service, diagnosis, description of Treatment or Service provided and extent of the loss. The Claims Administrator may request additional information to substantiate your loss or require a signed unaltered authorization to obtain that information from the provider. Your failure to comply with such request could result in declination of the claim. For Dental, the Claims Administrator may also require x-rays, dental charts, and other evidence needed to determine the dental condition treated and the services provided.

Payment, Denial, and Review

Up to 30 calendar days from receipt of claim is permitted for processing the claim. If a claim cannot be processed due to incomplete information, the Claims Administrator will send a written explanation prior to the expiration of the 30 calendar days. The Claimant is then allowed up to 45 calendar days to provide all additional information requested. The Claims Administrator will render a decision within 15 calendar days of either receiving the necessary information or upon expiration of 45 calendar days if no additional information is received.

In actual practice, benefits under the group plan may be processed and paid within a few days after the Claims Administrator receives completed proof of loss. If a claim cannot be paid, the Claims Administrator will promptly explain why.

A Claimant may request an appeal of a claim denial by written request to the Claims Administrator within 180 calendar days of receipt of notice of the denial. The Claims Administrator will make a full and fair review of the claim. The Claims Administrator may require additional information to make the review. The Claims Administrator will notify the claimant in writing of the appeal decision within 60 calendar days of receiving the appeal request. The first level of appeal review must be completed before filing a civil action or pursuing any other legal remedies.

After exhaustion of the formal appeal process, a Claimant may request a voluntary appeal. The appeal must be requested in writing. The Claimant may submit written comments, documents, re-

cords, and other information relating to the claim for benefits. The Claims Administrator will make a determination within 60 calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, the Claims Administrator will send a written explanation of the additional information that is required or an authorization for the Claimant's signature so information can be obtained from the provider. This information must be sent to the Claims Administrator within 45 calendar days of the date of the written request for the information. Failure to comply with the request for additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 60 calendar days of the receipt of all necessary information to properly review the appeal request.

Election of a second appeal is voluntary and does not negate the Claimant's right to bring civil action following the first appeal, nor does it have any effect on the Claimant's right to any other benefit under the group plan. The voluntary appeal process is offered in an effort that the claim may be resolved in good faith without legal intervention. At anytime during the voluntary appeal process, the Claimant may file a civil action or pursue any other legal remedies.

For purposes of this section, "Claimant" means you, your Dependent, or Beneficiary.

Benefit Advice

A benefit consulting service is available for you and your Dependents to provide information about the best use of your medical benefits. Examples of information you may find helpful include:

- general information on:

  - how to determine when outpatient care might be more appropriate; and
  - types of services offered by various health care providers; and
  - other treatment options available;

  without affecting the quality of your health care; and

- specific information such as:

  - the Prevailing Charge for a particular medical or surgical procedure; and
  - the average Hospital stay for a certain sickness or injury; and
  - how to obtain Physicians for second opinions on proposed surgery.

Call Our toll-free Health Info Line number (see your ID card or your employer for the Health Info Line number) if you wish to discuss medical benefits with Our benefit consultants.

Facility of Payment

The Planholder will normally pay all benefits (for other than orthodontia) to you. However, if the claimed benefits result from a Dependent's sickness or injury, the Planholder may make payment to the Dependent. Orthodontia benefits will be payable as described below. Also, in the special instances listed below, payment will be as indicated. All payments so made will discharge the Planholder to the full extent of those payments.

- If payment amounts remain due upon your death, those amounts may, at the Planholder's option, be paid to your estate, spouse, child, or parent.

- If the Planholder believes a person is not legally able to give a valid receipt for a benefit payment, and no guardian has been appointed, the Planholder may pay whoever has assumed the care and support of the person.

- Benefits payable to a Preferred Provider will be paid directly to the Preferred Provider on behalf of you or a Dependent.

- Benefits payable to a Transplant Network Provider will be paid directly to the provider.

Payment of Orthodontia Benefits

The Planholder will pay orthodontia benefits:

- immediately upon receipt of proof that the initial treatment (including setting of the appliance or bands) has been completed; and

- at the end of each following calendar quarter upon receipt of proof that the Period of Dental Treatment has continued.

The benefit amount payable for the initial treatment will be actual charges, but not more than 1/3 of the total estimated Covered Charges for the entire Period of Dental Treatment.

The quarterly benefit amounts payable will be determined by averaging the remaining estimated Covered Charges over the estimated time required to complete the Period of Dental Treatment. Adjustments may be made when changes occur in the estimated Covered Charges or estimated Period of Dental Treatment time.

Payment of X-Ray and Laboratory Charges (Other than while Hospital Confined)

Payment of outpatient x-ray and laboratory charges will be made as follows:

- The PPO level of benefits will be paid only to Preferred Providers.

- If you or one of your Dependents goes to a PPO freestanding x-ray or laboratory facility, the Physician Visit Copay amount will apply and the PPO level of benefits will be paid. If the x-ray or laboratory facility is not a Preferred Provider, the level of benefits for Non-PPO Providers will apply.

- If you or one of your Dependents goes to a PPO or non-PPO Physician and the Physician sends a person's x-ray or laboratory work to a PPO facility for processing, the PPO level of benefits will be paid. If you or your Dependent is not seen by that facility, the Physician Visit Copay amount will not apply, but the PPO level of benefits will be paid.

- If you or one of your Dependents goes to a PPO or non-PPO Physician and the Physician sends a person's x-ray or laboratory work to a non-PPO facility, the level of benefits and applicable Deductible(s) for Non-PPO Providers will apply.

If you or one of your Dependents is referred to another provider, ask if that provider is a Preferred Provider. Examples of this would be an anesthesiologist, x-ray or laboratory facilities, surgeons, etc. If that provider is not a Preferred Provider, the level of benefits for Non-PPO Providers will apply.

Medical Examinations

We or the Planholder may have the person whose loss is the basis for claim examined by a Physician. We will pay for these examinations and will choose the Physician to perform them.

Dental Examinations

The Planholder may have the person whose loss is the basis for dental claim examined by a Dentist. The Planholder will pay for these examinations and will choose the Dentist to perform them.

Legal Action

Legal action for a claim may not be started earlier than 90 calendar days after proof of loss is filed and before the appeal procedures have been exhausted. Further, no legal action may be started later than three years after proof is required to be filed.

Time Limits

All time limits listed in this section will be extended to meet any minimums required by law.

DEFINITIONS

Several words and phrases used to describe your plan are capitalized whenever they are used in this booklet. These words and phrases have special meanings as explained in this section.

Accidental Injury (for Dental Expense Coverage) means an injury to the natural teeth that is caused by an accident. Not included is any injury that results from chewing.

Active Work; Actively at Work (for Employee Life Insurance, and Optical, Retail and Mail Order Prescription Drugs, and Dental Expense Coverage) mean the active performance of all of a Employee's normal job duties at the City's usual place or places or business.

Ambulatory Surgery Center means a facility designed to provide surgical care which does not require hospital inpatient confinement but is at a level above what is available in a Physician's office or clinic. An Ambulatory Surgery Center:

- is licensed by the proper authority of the state in which it is located, has an organized Physician staff, and has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; and

- provides Physician services and full-time skilled nursing services directed by a licensed registered nurse (R.N.) whenever a patient is in the facility; and

- does not provide the services or other accommodations for hospital inpatient confinement; and

- is not a facility used as an office or clinic for the private practice of a Physician or other professional providers.

Birthing Center means a freestanding facility that is licensed by the proper authority of the state in which it is located and that:

- provides prenatal care, delivery, and immediate postpartum care; and

- operates under the direction of a Physician who is a specialist in obstetrics and gynecology; and

- has a Physician or certified nurse midwife present at all births and during the immediate postpartum period; and

- provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by a licensed registered nurse (R.N.) or certified nurse midwife; and

- has a written agreement with a Hospital in the area for emergency transfer of a patient or a newborn child, with written procedures for such transfer being displayed and staff members being aware of such procedures.

Brand Name Prescription Drug; Brand Name Drug means a drug that is customarily recognized throughout the pharmaceutical profession as the original or trademarked preparation of a drug entity and for which the Food and Drug Administration (FDA) has given general marketing approval.

Calendar Year means that period of time beginning on the first day of January in any year and ending on the last day of December in the same year.

City means Council Bluffs, Iowa.

Claims Administrator means Principal Life Insurance Company, Des Moines, Iowa.

Complete Visual Analysis (for Optical Expense Coverage) includes:

- case history and professional consultation; and
- examination for disease or abnormalities; and
- determination of the ranges of clear single vision; and
- measurement of refraction, eye muscle coordination, and balance; and
- special working distance analysis.

Concurrent Review means a Utilization Review conducted during a patient's Hospital stay or course of treatment.

Continued Stay Review means a review by the Cost Containment Administrator of a Physician's report of the need for continued Hospital Inpatient Confinement to determine if the continued stay is for Medically Necessary Care.

Copay means a specified dollar amount that must be paid by you or a Dependent each time certain or specified services are rendered.

Cosmetic Procedures and Services means Treatment or Service to change:

- the texture or appearance of the skin; or
- the relative size or position of any part of the body;

when such procedure or service is performed primarily for psychological purposes or is not needed to correct or improve a bodily function. Cosmetic Procedures and Services include, but are not limited to, pharmacological regimens, nutritional procedures or treatments, and reconstructive surgery, and all related charges.

Cost Containment Administrator means the organizations designated on your or your Dependent's ID card.

Covered Charges mean the actual cost charged to you or one of your Dependents for Medically Necessary Care, but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Custodial Care means assistance with meeting personal needs or the Activities of Daily Living.

For this purpose, "Activities of Daily Living" means activities that do not require the services of a Physician, registered nurse (R.N.) licensed practical nurse (L.P.N.), or other health care professional

including, but not limited to, bathing, dressing, getting in and out of bed, feeding, walking, elimination, and taking medications.

Deductible; Deductible Amount means a specified dollar amount of Covered Charges that must be incurred by the covered person before benefits will be payable under the plan for all or part of the remaining Covered Charges during the calendar year.

Dental Hygienist means a person who works under the supervision of a Dentist and is licensed to practice dental hygiene.

Dental Services means any confinement, treatment, or service, provided to diagnose, prevent or correct:

- periodontal disease (disease of the surrounding and supplemental tissues of the teeth, including deformities of the bone surrounding the teeth); and/or
- malocclusion (abnormal positioning and/or relationship of the teeth); and/or
- ailments or defects of the teeth and supporting tissue and bone (excluding impacted teeth and appliances used to close an acquired or congenital opening). However, the term **Dental Services** will include treatment performed to replace or restore any natural teeth in conjunction with the use of any such appliance.

Dental Treatment Plan means the Dentist's report of proposed treatment which:

- is written on a form provided by the Claims Administrator; and
- lists the procedures required for the Period of Dental Treatment; and
- shows the charges for each procedure; and
- is accompanied by any diagnostic materials that the Claims Administrator might require.

Dentist means:

- a person licensed to practice dentistry; and
- a licensed Physician who provides dental treatment or service.

Dependent means:

- your spouse, if not in the Armed Forces of any country, and not covered as an Employee; and
- <u>for Dependent Life Insurance</u>: Your unmarried natural or legally adopted children age 14 days to 19 years of age, if not in the Armed Forces of any country, and not covered as an Employee; and
- <u>for Medical, Optical, Retail and Mail Order Prescription Drug, and Dental Expense Coverages</u>: Your unmarried natural or legally adopted children to 19 years of age, if not in the Armed Forces of any country, and not covered as an Employee; and

- for all coverages: Your unmarried natural or legally adopted children 19 years but less than 24 years of age, if supported by you, enrolled as a Full-Time Student as defined, not in the Armed Forces of any country, and not covered as an Employee.

  A newly adopted child will be considered a Dependent from the date of Placement with you for the purpose of adoption or the date of adoption, whichever is earlier. The child will continue to be a dependent unless the Placement is disrupted prior to legal adoption and the child is removed from Placement.

- Your stepchildren or foster children, living with you, if approved in writing.

Dependent (for Comprehensive Medical and Dental Expense Coverage) will also include any child covered under a Qualified Medical Child Support Order (QMCSO) as defined by applicable federal law provided the child meets the definition of Dependent.

Dependent (for retired Employees) means only those Dependents who were covered under this plan on your date of retirement.

Developmental Disability means a child's substantial handicap which:

- results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder; and

- is diagnosed by a Physician as a permanent or long-term continuing condition.

Disability; Disabled mean your inability, because of sickness or injury, to work at any job that reasonably fits your background and training.

Durable Medical Equipment means equipment that:

- can withstand repeated use; and

- is primarily and customarily used to serve a medical purpose; and

- is generally not useful to a person who is not sick or injured, or used by other family members; and

- is appropriate for home use; and

- improves bodily function caused by sickness or injury, or further prevents deterioration of the medical condition

Early Retiree; Early Retirement means a former Employee who terminates active employment before age 65 and is receiving a retirement benefit in accordance with Chapters 97B and 411 of the code of Iowa.

Employee means any Full-Time Regular Employee (see definition below) of the City, authorized to receive coverage under this plan by labor contract or City Council action.

Employer means the City of Council Bluffs, Iowa.

Episode of Hospice Care means the period of time:

- beginning on the date a Hospice Care Program is established for a dying individual; and

- ending on the earlier of the date six months after the date the Hospice Care Program is established, the date the attending Physician withdraws approval of the Hospice Care Program, the date the individual recovers or the date the individual dies.

Two or more Episodes of Hospice Care for the same individual will be considered one Episode of Hospice Care, unless separated by a period of at least three months during which no Hospice Care Program is in effect for the individual.

Experimental or Investigational Measures mean any Treatment or Service, regardless of any claimed therapeutic value, not Generally Accepted by specialists in that particular field of medicine or dentistry, as determined by the Claims Administrator.

Full-Time Regular Employee means an employee who fills a position which has a normal work schedule of at least 40 hours and the duration of the assignment is of a continuing nature with no limitations. Employees who are hired to fill a full-time, regular position will be eligible for full benefits as authorized by the City Council of Council Bluffs, Iowa, subject to plan restrictions.

Full-Time; **Full-Time Student** means your Dependent child who:

- physically attends classes at a school with a regular teaching staff, curriculum, and student body; and

- attends the school for the number of credits, hours, or courses required by the school for full-time students. For this purpose, school vacation (excluding a school vacation immediately after graduation) will be considered a part of full-time school attendance. If a child leaves school during a school term due to sickness or injury, he or she will be considered a full-time student until the earlier of:

    - the end of the school term; or

    - for Dependent Life Insurance, the date he or she ceases to be in a Period of Limited Activity due to the sickness or injury.

Generally Accepted means treatment or service that:

- has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed medical and scientific literature; and

- is in general use in the medical community in the state in which this Plan is established; and

- is not under continued scientific testing or research as a therapy for the particular sickness or injury which is the subject of claim.

Generic Prescription Drugs mean Covered Charges for biologically equivalent pharmaceutical products manufactured and sold under their chemical, common, or official name.

The majority of Generic Prescription Drugs are available at the lowest generic Copay. However, some generics are more expensive and are priced comparable to the Brand Name Drug. In those

situations, you may be charged the Brand Name Drug Copay. In order to qualify for the generic Copay, a drug must be classified as generic by First DataBank/Medispan.

Health Care Extender means an allied health practitioner who is delivering medical services under the direction and supervision of a Physician.

Direction and supervision means the Physician co-signs any progress notes written by the Health Care Extender; or there is a legal agreement that places overall responsibility for the Health Care Extender's services on the Physician.

Health Professional means an individual who:

- has undergone formal training in a health care field;
- holds an associate or higher degree in a health care field, or holds a state license or state certificate in a health care field; and
- has professional experience in providing direct patient care.

Home Health Aide means a person, other than a registered nurse, who provides medical or therapeutic care under the supervision of a Home Health Care Agency.

Home Health Care Agency means a Hospital, agency, or other service that is certified by the proper authority of the state in which it is located to provide home health care.

Home Health Care Plan means a program of home care that:

- is required as a result of a sickness or injury; and
- follows a period of Hospital confinement; and
- is a result of the sickness or injury that was the cause of the Hospital confinement; and
- is established in writing by the attending Physician within seven days after Hospital confinement ends; and
- is certified by the attending Physician as a replacement for Hospital confinement that would otherwise be necessary.

Hospice means a facility, agency, or service that:

- is licensed, accredited, or approved by the proper regulatory authority to establish and manage Hospice Care Programs; and
- arranges, coordinates, and/or provides Hospice Care Services for dying individuals and their families; and
- maintains records of Hospice Care Services provided and bills for such services on a consolidated basis.

Hospice Care Program means a program:

- managed by a Hospice; and
- established jointly by a Hospice, a Hospice Care Team, and an attending Physician;

to meet the special physical, psychological, and spiritual needs of dying individuals and their families.

Hospice Care Team means a group that provides coordinated Hospice Care Services and normally includes:

- a Physician;
- a patient care coordinator (Physician or nurse who serves as an intermediary between the program and the attending Physician);
- a nurse;
- a mental health specialist;
- a social worker;
- a chaplain; and
- lay volunteers.

Hospital means an institution that is:

- licensed as a hospital by the proper authority of the state in which it is located; and
- recognized as a hospital by the Joint Commission on Accreditation of Healthcare Organizations;

but not including any institution, or part thereof, that is used primarily as a clinic, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

Hospital Admission Review means a review by the Cost Containment of a Physician's report of the need for Hospital Inpatient Confinement (scheduled or emergency) to determine if the confinement is for Medically Necessary Care.

Hospital Inpatient Confined; Hospital Inpatient Confinement means any period of Treatment or Service in a hospital in excess of 23 consecutive hours for any cause. A Hospital Admission Review is required for all Hospital Inpatient Confinements.

Hospital Inpatient Confinement Charges mean Covered Charges by a Hospital for room, board, and other usual services and by a Physician for pathology, radiology, or the administration of anesthesia.

Hospital Room Maximum means Covered Charges by a Hospital for room and board while confined in a private room up to:

- the Hospital's most frequent semiprivate room rate, if the Hospital has semiprivate rooms; or

- the Hospital's most frequent private room rate, if the Hospital has no semiprivate rooms.

Hospitalization Charges mean Covered Charges by a Hospital for room, board, and other usual services and by a Physician for pathology, radiology, or the administration of anesthesia while confined in a Hospital. Such charges must be incurred while the person is confined:

- for a period of a least 23 consecutive hours (for any cause); or

- for any period of time while undergoing surgery or while receiving emergency treatment as a result of and within 24 hours after an injury.

Immediate Family means a covered person's husband or wife, natural or adoptive parent, child or sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, or spouse of grandparent or grandchild.

Initial Clinical Review(er) means a Clinical review conducted by appropriate licensed or certified Health Professionals. Initial Clinical Review staff may approve requests for admissions, procedures, and services that meet clinical review criteria, but must refer requests that do not meet clinical review criteria to a Peer Clinical Reviewer for certification or Noncertification.

Medical Emergency means the sudden onset of severe medical symptoms that:

- could not have been reasonably anticipated; and

- require immediate medical treatment.

Medically Necessary Care means any confinement, treatment, or service that is prescribed by a Physician and considered by the Claims Administrator to be:

- necessary and appropriate; and

- nonexperimental or non-investigational and not in conflict with Generally Accepted medical standards.

Member Pharmacy (for Prescription Drugs Expense Coverage) means any pharmacy that is a participating member of AdvancePCS, the claims administrator for your Prescription Drugs benefits.

Noncertification means a determination by the Cost Containment Administrator that an admission, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the Cost Containment Administrator's requirements for Medically Necessary Care, appropriateness, health care setting level of care or effectiveness, and the request is therefore denied, reduced, or terminated.

Nonmember Pharmacy (for Prescription Drugs Expense Coverage) means any pharmacy that is not a participating member of AdvancePCS.

Non-PPO Provider means a Hospital, Physician, or other provider who has not agreed to participate in the Preferred Provider Organization (PPO) network established by Principal Health Care, Inc.

Notification of Utilization Review Services mean receipt of necessary information to initiate review of a request for Utilization Review services to include the patient's name and your name (if different from patient's name), attending Physician's name, treating facility's name, diagnosis, and date of service.

Nursing Facility means an institution, or distinct part thereof, that is licensed to provide skilled nursing care for persons recovering from sickness or injury and that:

- is supervised on a full-time basis by a Physician or a graduate registered nurse; and
- has transfer arrangements with one or more Hospitals, a utilization review plan, and operating policies developed and monitored by a professional group that includes at least one Physician; and
- has a contract for the services of a Physician, maintains daily records on each patient and is equipped to dispense and administer drugs; and
- provides 24-hour nursing care and other medical treatment.

Not included are rest homes, homes for the aged, or places for treatment of mental disease, drug addiction, or alcoholism.

Optometrist (for Optical Expense Coverage) means a person who is licensed to practice optometry.

Ordering Provider means the Physician or other provider who specifically prescribes the health care service being reviewed.

Orthodontic Treatment or Service means any Treatment or Service for:

- straightening of teeth, formal, full-banded retention and treatment, including x-rays and other diagnostic procedures; and
- removable or fixed appliances for tooth or bony structure guidance or retention.

Out-of-Pocket Expenses means Covered Charges for confinement, treatment, or service for which no benefits are payable because of Deductible, and coinsurance features.

Outpatient Treatment means treatment or service provided by a Physician, a Hospital, or other licensed or state-approved treatment facility which occurs other than while confined in a Hospital for 23 or more consecutive hours.

Payment Schedule (for Prescription Drugs Expense Coverage) means the maximum reimbursement amount allowed under the program as established by the Plan administrator.

Pediatric Vaccine means those vaccines shown on the list established and periodically reviewed by the Advisory Committee on Immunization Practices as referenced by Section 1928 of Title 19 of the Social Security Act or such other list of vaccines as mandated by other Federal or State laws that are applicable to this plan.

Peer Clinical Review(er) means a Clinical review conducted by a Physician or other Health Professional when a request for an admission, procedure, or service was not approved during the Initial Clinical Review.

In the case of an appeal review, the Peer Clinical Reviewer is a Physician or other Health Professional who holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category as the Ordering Provider.

Period of Dental Treatment means all sessions of dental care that result from the same initial diagnosis and any related complications. For Orthodontia, Period of Dental Treatment means all treatment performed in the oral cavity during one or more sessions as the result of the same initial diagnosis for the detection, prevention, and correction of abnormalities in the positioning of teeth in their relationship to the jaw and of associated deformities and dysfunctions.

Period of Limited Activity (for Dependent Life Insurance) means any period of time during which a person is:

- confined in a Hospital or Nursing Facility; or
- whether confined or not, is unable to carry on the regular and usual activities of a healthy person of the same age and sex.

Pharmacy Benefit Manager means AdvancePCS.

Physical Handicap means a Dependent child's substantial physical or mental impairment which:

- results from injury, accident, congenital defect, or sickness; and
- is diagnosed by a Physician as a permanent or long-term dysfunction or malformation of the body.

Physician means:

- a licensed Doctor of Medicine or Osteopathy; and
- any other licensed health care practitioner that state law requires be recognized as a Physician under your benefit plan.

Physician Visit means a face-to-face meeting between a Physician and a patient for the purpose of medical treatment or service.

Physician Visit Charges means Covered Charges for Treatment or Service furnished at a Physician's clinic or office or by a Physician at your or your Dependent's home. Such services include charges for: dressings; supplies (other than orthotics and braces); equipment; injections; anesthesia; take-home drugs; blood; blood plasma; x-ray and laboratory examinations; x-ray, radium, and radioactive isotope therapy; and routine physical examinations.

Placement for Adoption; Placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adopting the child. The child's placement with the person terminates upon the termination of such legal obligation.

Plan Administrator; Planholder means City of Council Bluffs, Iowa.

Preferred Provider means a Hospital, Physician, or other provider who has agreed to participate in the Preferred Provider Organization (PPO) network identified by the Claims Administrator for this plan.

Prescription Legend Drugs (for Prescription Drugs Expense Coverage) mean any medicinal substance, the label of which under the Federal Food, Drug and Cosmetic Act is required to bear the legend, "Caution, Federal Law prohibits dispensing without a prescription."

Prevailing Charges (for Dental Expense Coverage) means:

- As determined by the Plan administrator, the amount that most dental care providers charge within a geographic cost area charge for a Treatment or Service.

- For purposes of coverage provided under this plan, an actual charge for a Treatment or Service will be in excess of Prevailing Charges if, as determined by the Plan administrator, 90% or more of all other charges reported to the Plan administrator for the same (or a similar) Treatment or Service provided within the same (or a comparable) cost area are lower in amount than the actual charge.

Prevailing Charges (for Medical Expense Coverage) means:

- For medical care received from Preferred Providers, the amount based on the negotiated fee between the Preferred Provider and the PPO network.

- For medical care received from Non-PPO Providers, the amount, as determined by the Plan administrator, that most health care providers within a geographic cost area charge for a Treatment or Service.

  For this Plan, an actual charge for a Treatment or Service will be in excess of Prevailing Charges only if, as determined by the Plan administrator, 90% or more of all other charges reported to the Plan administrator for the same (or a similar) Treatment or Service provided within the same (or a comparable) cost area are lower in amount than the actual charge.

- For drugs and medicines requiring a Physician's prescription and considered a covered Treatment or Service, if the Prevailing Charge cannot be determined as described above, Average Wholesale Price will be applied.

- For medical care received from a Transplant Network Provider, the amount will be based on the negotiated fee.

Prospective Review means a Utilization Review conducted prior to a patient's stay in a Hospital or other health care facility or course of treatment, including any required preauthorization or precertification.

Psychologist means an individual in private practice who is legally licensed to practice psychology by a governmental authority which has jurisdiction over the licensure and practice of psychology.

Retrospective Review means a Utilization Review conducted after the patient is discharged from a Hospital or other health care facility or has completed a course of treatment.

Transplant Network Provider means any Physician or facility determined to be an appropriate transplant provider and that has contracted to provide Transplant Services subject to a negotiated fee schedule.

Treatment or Service means confinement, treatment, service, substance, material, or device.

Urgent Review means a Utilization Review that must be completed sooner than a Prospective Review in order to prevent serious jeopardy to your or the patient's life or health or the ability to regain maximum function, or in the opinion of a Physician with knowledge of your or the patient's medical condition, would subject you or the patient to severe pain that cannot be adequately managed without treatment. Whether or not there is a need for an Urgent Review is based upon the Cost Containment Administrator's determination using the judgement of a prudent layperson who possess an average knowledge of health and medicine.

Utilization Review means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities.

We, Us, and Our mean Principal Life Insurance Company, Des Moines, Iowa.

COMPLAINT PROCEDURES

Any eligible Employee, Dependent, or Retiree may file a complaint with the Personnel Department concerning the Group Medical, Optical or Dental Expense Coverage within 160 days of any action taken by the City or the Claims administrator.

Complaints concerning the payment or denial of a claim will be forwarded to the Claims Administrator within 20 days and shall be processed according to the Payment, Denial, and review procedures described on page 83 of this booklet. Complaints of this nature may also be filed directly with the Claim Administrator.

Complaints or requests to review a decision of the Claims administrator for Noncertification of a Hospital admission or service shall be made according to the Utilization Review Program described on pages 45 of this booklet.

Any other complaints or requests for review of other matters will be processed as follows:

- The Personnel Director will forward the complaint to the Claims Administrator who will, within 60 days after review of the complaint, provide a written decision concerning the complaint. If the Claims Administrator satisfies the complaint, it shall so notify the Personnel Director.

- When the complaint has not been satisfied, the Personnel Director will notify the complainant within 14 days of his or her rights to file a written formal complaint. The written formal complaint must be submitted to the Mayor within 30 days from the date such notice is given by the Personnel Director. Upon the receipt of a formal complaint the Mayor shall refer the complaint to the health coverage review committee.

- The health coverage review committee will be composed of the Mayor, City Attorney, and the Personnel Director, or a designated representative of these officials. The committee will ascertain the facts and have the power to enforce its decision. The committee will make a written decision within 60 days. A copy of this decision shall be sent to the complainant by certified mail.

CITY OF COUNCIL BLUFFS, IA

Notice of Privacy Practices for Personal Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

NOTE: "We" as used in this notice means the City of Council Bluffs, IA.

This Notice of Privacy Practices describes the City of Council Bluffs group insurance practices for safeguarding individually identifiable personal health information. The terms of this Notice apply to members and their dependents for their health, prescription drug, dental, and optical coverages. This Notice is effective April 14, 2003.

We are required by law to maintain the privacy of our members' and their dependents' personal health information and to provide notice of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all personal health information maintained by us. Copies of revised Notices will be mailed to you. You have the right to request a paper copy of the Notice.

Business Associate. Most aspects and components of our services are performed by outside people or organizations pursuant to agreements or contracts. For example, Principal Life Insurance Company provides administrative services to our plan including receiving and processing health, dental and optical claims. It is necessary for us to disclose your personal health information to these outside people or organizations that perform services on our behalf. We require them to appropriately safeguard the privacy of your personal health information through a separate agreement with them. These business associates may disclose private health information to the extent that such use or disclosure would not violate the Privacy Rule if done by the City of Council Bluffs.

Uses and Disclosures of Your Personal Health Information

Authorization. Except as explained below, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing a use or disclosure. Unless we have taken any action in reliance on the authorization, you have the right to revoke an authorization if the request for revocation is in writing and sent to: Asst. Director of Personnel, Cindy Lynch, Personnel Department, 209 Pearl Street, Council Bluffs, IA 51503. A copy of your request will also be forwarded to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002.

Disclosures for Treatment. We may disclose your personal health information as necessary for your treatment. For instance, a doctor or health care facility involved in your care may request your personal health information in our possession to assist in your care.

Uses and Disclosures for Payment. We will use and disclose your personal health information as necessary for payment purposes. For instance, we may use your personal health information to process or pay claims, for subrogation, to perform a hospital admission review to determine whether services are for medically necessary care or to perform

prospective reviews. We may also forward information to another health plan in order for it to process or pay claims on your behalf.

Uses and Disclosures for Health Care Operations. We will use and disclose your personal health information as necessary for health care operations. For instance, we may use or disclose your personal health information for quality assessment and quality improvement, credentialing health care providers, premium rating, conducting or arranging for medical review or compliance. We may also disclose your personal health information to another health plan, health care facility or health care provider for activities such as quality assurance or case management. We may also contact your health care providers concerning prescription drug or treatment alternatives.

Other Health-Related Uses and Disclosures. We may also contact you to provide reminders for appointments; information about treatment alternatives; other health-related programs, products or services that may be available to you.

Plan Sponsors. We may disclose your personal health information to the plan sponsor, provided that the plan sponsor certifies that the information will be maintained in a confidential manner and will not be utilized or disclosed for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.

Family, Friends and Personal Representatives. With your approval, we may disclose to family members, close personal friends, or another person you identify, your personal health information relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated or involved in an emergency situation, and we determine that a limited disclosure is in your best interests, we may disclose your personal health information without your approval. We may also disclose your personal health information to public or private entities to assist in disaster relief efforts.

Other Uses and Disclosures. We are permitted or required by law to use or disclose your personal health information, without your authorization, in the following circumstances:

- For any purpose required by law;
- For public health activities (for example, reporting of disease, injury, birth, death or suspicion of child abuse or neglect);
- To a governmental authority if we believe an individual is a victim of abuse, neglect or domestic violence;
- For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions);
- For judicial or administrative proceedings (for example, pursuant to a court order, subpoena or discovery request);
- For law enforcement purposes (for example, reporting wounds or injuries or for identifying or locating suspects, witnesses or missing people);
- To coroners and funeral directors;
- For procurement, banking or transplantation of organ, eye or tissue donations;
- For certain research purposes;
- To avert a serious threat to health or safety under certain circumstances;
- For military activities if you are a member of the armed forces; for intelligence or national security issues; or about an inmate or an individual to a correctional institution or law enforcement official having custody; and
- For compliance with workers' compensation or other injury on the job programs.

We will adhere to all applicable state and federal laws or regulations that provide additional privacy protections. We will only use or disclose AIDS/HIV-related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by state and federal law or regulation.

Your Rights

Restrictions on Use and Disclosure of Your Personal Health Information. You have the right to request restrictions on how we use or disclose your personal health information for treatment, payment or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your care or the paying of your care. To request a restriction, you must send a written request to: Asst. Director of Personnel, Cindy Lynch, Personnel Department, 209 Pearl Street, Council Bluffs, IA 51503. The City will forward a copy of this request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002. We are not required to agree to your request for a restriction. You will be notified in writing as to whether or not your request for a restriction is granted.

Receiving Confidential Communications of Your Personal Health Information. You have the right to request communications regarding your personal health information from us by alternative means (for example by fax) or at alternative locations. We will accommodate reasonable requests. To request a confidential communication, you must send a written request to: Asst. Director of Personnel, Cindy Lynch, Personnel Department, 209 Pearl Street, Council Bluffs, IA 51503. The City will forward a copy of this request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002.

Access to Your Personal Health Information. You have the right to inspect and/or obtain a copy of your personal health information we maintain in your designated record set, with a couple of exceptions. To request access to your information, you must send a written request to: Asst. Director of Personnel, Cindy Lynch, Personnel Department, 209 Pearl Street, Council Bluffs, IA 51503. The City will forward a copy of this request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002.

Amendment of Your Personal Health Information. You have the right to request an amendment to your personal health information to correct inaccuracies. To request an amendment, you must send a written request to: Asst. Director of Personnel, Cindy Lynch, Personnel Department, 209 Pearl Street, Council Bluffs, IA 51503. The City will forward a copy of this request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002. We are not required to grant the request in certain circumstances.

Accounting of Disclosures of Your Personal Health Information. You have the right to receive an accounting of certain disclosures made by us after April 14, 2003 of your personal health information. To request an accounting, you must send a written request to: Asst. Director of Personnel, Cindy Lynch, Personnel Department, 209 Pearl Street, Council Bluffs, IA 51503. The City will forward a copy of this request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002. The first accounting in any 12-month period will be free;

however, a fee will be charged for any subsequent request for an accounting during that same time period.

Complaints. If you believe your privacy rights have been violated, you can send a written complaint to us at: Asst. Director of Personnel, Cindy Lynch, Personnel Department, 209 Pearl Street, Council Bluffs, IA 51503 ***or*** to the Secretary of the U.S. Department of Health and Human Services. The City will forward a copy of any complaint received to the Grievance Coordinator, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002. There will be no retaliation for filing a complaint.

If you have any questions or need any assistance regarding this Notice or your privacy rights, you may contact Asst. Director of Personnel, Cindy Lynch, Personnel Department, 209 Pearl Street, Council Bluffs, IA 51503.

Notes